Examining the role of social context in nurses' pain assessment practice with postoperative clients
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EXAMINING THE ROLE OF SOCIAL CONTEXT IN
NURSES’ PAIN ASSESSMENT PRACTICE
WITH POSTOPERATIVE CLIENTS

BY
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A DISSERTATION SUBMITTED IN PARTIAL FULFILLMENT OF THE
REQUIREMENTS FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY
IN
NURSING

UNIVERSITY OF RHODE ISLAND
2004
ABSTRACT

Pain is a significant symptom in the postoperative period. Inadequately managed pain has been associated with additional postoperative complications and prolonged hospitalization, yet empirical data demonstrate that nurses frequently use inaccurate assessment criteria, and clients report inadequate pain management. Interventions designed to change nurses' assessment of pain have not addressed the impact of the setting in which practice occurs. This study was designed to describe the impact of the sociocultural context of the practice setting on nurses' assessment of postoperative patients' pain.

The study was guided by Bourdieu's theory of practice which proposes that each instance of human practice is a mediation between structures within the individual and structures within the context of practice. Bourdieu describes the practice of individuals, situated within structured social fields, using three foundational concepts: field, capital and habitus.

Initially, a quantitative instrument, The Pain Assessment Inventory, which assesses strategies that nurses use to assess pain in postoperative clients, was developed using classic ethnographic techniques and tested in a sample of one hundred and ninety three (193) Registered Nurses.

A four phase ethnography was conducted simultaneously on two postoperative units of a large teaching hospital in New England. Using classic ethnographic techniques, data collection and analysis were conducted in distinct phases, designed to address specific research questions: (1) the nature of sociocultural field of nursing pain assessment practice in each unit; (2) the specific
assessment strategies used in each field; (3) identification of the predominant nursing pain assessment habitus in each field; and (4) differences in nursing pain assessment habitus between the fields. Data collection methods included participant observation over a six month period; in-depth interviews with twenty nurses; focus groups conducted on each unit, and use of a quantitative survey instrument.

A predominant pattern of nursing pain assessment was observed on each unit. Nurses used assessment criteria from three spheres including the client's narrative of pain, evident criteria demonstrated by the client and a reference typology of expected pain assessment findings. Nurses demonstrated the use of a single sphere of criteria as a primary filter through which data from the other two spheres was processed.
ACKNOWLEDGMENTS

My journey through doctorial education has been supported by so many people, many of whom have made substantial contributions to the completion of this dissertation. First among these is Dr. Hesook Suzie Kim. Suzie has been a tremendous mentor and champion of this work. She has challenged me to think in new and different ways, and supported the use of a nontraditional approach to the study of a common problem. She never seemed to tire of my incessant questions aimed at a greater understanding of the theory, and her own seminal work in nursing theory served to locate this work within the context of the practice domain. Her enthusiasm for empirical study and theoretical development in the practice domain gave me confidence in the value of this work. I am so grateful for the opportunity to work with her. Dr. Donna Schwartz-Barcott gave me the courage to pursue ethnography, and each of our many discussions served to sharpen my thinking. She is a tremendous role model and now a deeply valued colleague. Dr. Bjorn Sjostrom’s work on pain assessment formed the basis for the development of the Pain Assessment Inventory. Bjorn was always willing to spend time with me during his visits to Rhode Island, and provided valuable guidance to the development of the study.

The nurses who participated in the study gave generously of their time and experience. Without their patience and support, and their thoughtful reflection on their own practice, this study would hold far less value.

Throughout my career, I have been privileged to have had wonderful role models and mentors. Dr. Judith Ritchie provided my first image of the nurse-
scholar. She has served as mentor, role model and friend...and I am grateful. Carolanne Vair taught me more than she knows about the role of the ethical, visionary nurse administrator. Fran Wertman, a wonderful friend, has spent countless patient hours listening to me describe my work, and these discussions have always been more than helpful. My dear friend Alexandra Hirth was my first research colleague. She is never forgotten.

The instrument development portion of this work was funded through a research award from Delta Upsilon Chapter-at-Large, Sigma Theta Tau. I am very grateful for their support.

Beyond support for the scholarly work, I have had tremendous personal support throughout my doctoral study. Family and friends have been unfailingly encouraging, and have forgiven my single-minded focus over the past five years. In particular, my parents, Rhoda & Roy Lauzon, instilled a love of learning that began long before my formal education, and they continue to provide love and encouragement. I am so grateful.

Finally, my husband Glenn’s role can only be described as heroic. I began graduate school less than one year into our marriage, and he has never complained about my frequent absences, and my never-ending absorption in this study. He has done more than I would think was humanly possible to encourage and support me. Only he knows how much he has sacrificed to allow me to pursue this goal, and he has done so with unending grace and patience. While I have occasionally questioned myself and my decisions along this path, I have never doubted that I am completely and unconditionally loved. I only hope that he can say the same.
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CHAPTER ONE

INTRODUCTION

Pain is a major presenting symptom in the postoperative period, and inadequate treatment of postoperative pain has been associated with prolonged hospitalization, increased morbidity and delayed return to activities of daily living (AHCPR, 1992). These negative outcomes have substantial impact on both the economic costs of surgical intervention for the health care system, and economic as well as physiological, psychological and social consequences for clients. These impacts have been widely recognized, and in 1992, the Association for Health Care Policy Research released one of its earliest clinical practice guidelines, addressing the management of acute pain following operative or medical procedures or trauma (AHCPR, 1992). Despite the fact that ten years have passed since these guidelines were issued, there are still significant issues surrounding the management of postoperative pain. Postoperative clients continue to report experiencing moderate to severe pain (Bostrom, Ramberg, Davis, D., & Fridlund, 1997), describe their pain control in the postoperative period as inadequate or ineffective (Berndtsson, Hulten, & Oresland, 1996; Carr & Thomas, 1997; Carroll et al., 1999; Devine et al., 1999; White, 1999), and report being inadequately informed regarding pain and pain management (Carr & Thomas, 1997).

Nurses play a central role in the assessment and management of pain in the postoperative period. Pain has been proposed to be the most nurse-sensitive outcome in this client population (AHCPR, 1992). Nurses are primarily
responsible for ongoing assessment of a client’s postoperative pain experience. Further, based on these assessments nurses have access to a wide variety of both pharmacological and nonpharmacological measures to manage pain. Generally, nonpharmacological measures (for example positioning, splinting, therapeutic touch) are implemented solely at the nurses’ discretion. Pharmacological treatment of pain requires a physician’s order, but postoperative analgesic orders generally give nurses a relatively wide range of latitude in both the dosage and frequency of administration of medications. In some settings, nurses also choose between several analgesics ordered for the client on the basis of their assessment. Most typically, nurses make decisions about when the client is able to switch from injectable analgesics to oral analgesia. In recent years, the use of patient-controlled analgesia (PCA) has become routine practice in many settings. Use of PCA does not change the fact that the nurse remains the primary caregiver responsible to assess the client’s pain, to monitor the client’s response to analgesia and to suggest changes to the dose of analgesic provided to the physician.

Inadequate management of pain has been recognized as a central problem in nursing practice for decades. Empirical work on nurses' assessment and treatment of pain has generated a significant body of knowledge aimed at improving practice. However, there is also consensus that there remains considerable room for improvements in practice with respect to nurses’ assessment and management of pain in the postoperative period (Al-Hassan, Alkhalil, & Al
Ma'aitah, 1999; Bell & Reeves, 1999; Briggs & Dean, 1998; Dalton, 1989; Dalton et al., 1999; Dalton et al., 1998; Field, 1996; Natapoff, 2000).

To date, interventions designed to address nurses' assessment and management of postoperative pain have met with mixed degrees of success. The majority of work in this area has tended to focus on the practice of individual nurses, and to examine either variables in the nurse-client dyad or nurses' application of pain management knowledge. What these individual-focused approaches have failed to address is the notion that nursing is social practice. Hospital-based nursing is conducted within discreet nursing unit environments. A nurse provides care for a group of clients during an eight or twelve hour shift. Each of these clients will be cared for by other nurses during other hours of the day, and in this manner, the practice of each nurse is both visible to and shaped by the practice of others. It is within the context of a nursing unit that novice nurses are exposed to, learn and incorporate those practices which are seen as regular, routine and successful. Similarly, forms of practice which may be described as ineffective, irregular or out of the ordinary are also open to scrutiny and censure by others within the unit. Knowledge of specific unit culture may be essential to development of an adequate understanding of nurses' attitudes and behaviors (Coeling & Wilcox, 1988).

Nurses have also identified substantial barriers to implementation of appropriate pain management practices in the clinical environment. However, despite the fact that nurses identify factors in the practice environment as
significant barriers to appropriate pain management practices, interventions
designed to improve pain management practice have principally been directed at
the level of the individual practitioner.

This study is built upon the assumption that nursing practice is shaped by
the sociocultural field in which it occurs. It is proposed that the dynamic
relationship between the individual nurse's own dispositions and the sociocultural
field has a pervasive and persistent effect on how nurses conduct their practice in
all respects, including the assessment of postoperative pain, and that the specific
relationship will vary from practice setting to practice setting.

While a great deal of empirical effort has focused on nurses' assessment and
management of pain in a variety of client populations, this study proposes a line of
inquiry aimed at addressing nursing unit level influences specifically on the
assessment of postoperative pain for two reasons. First, pain has been identified
as a major symptom of the postoperative period, and inadequate pain management
has been associated with negative client outcomes, including increased morbidity
and prolonged length of stay (AHCPR, 1992). Secondly, the physiology of pain in
the postoperative client is well understood, and there are widely accepted
consensus guidelines describing strategies for adequate assessment and
management of pain in the postoperative period (AHCPR, 1992). However,
despite these guidelines, published reports continue to demonstrate that nurses'
rely on inaccurate and unscientific assessment criteria (Chuk, 1999; Coyne, Smith,
Stein, Heiser & Hoover, 1998; Dalton, 1989; Ferrell, Eberts, McCaffery, & Grant,
1991; Field, 1996a; Sjöström, Dahlgren & Haljamae, 2000), underestimate pain in this group (Al-Hassan, Alkhalil & Al Ma'aitah, 1999; Briggs & Dean, 1998; Field, 1996b; Sjöström, 1995; Sjöström et al., 2000), provide inadequate pain management (Bostrom et al., 1997; Carroll et al., 1999; Devine et al., 1999), fail to document pain assessment (Briggs & Dean, 1998; Camp & O'Sullivan, 1987; Carroll et al., 1999; Clarke et al., 1996; Coyne et al., 1998; Tittle & McMillan, 1994). Postoperative clients report inadequate treatment of pain (AHCPR, 1992; Carr & Thomas, 1997; Carroll et al., 1999; Devine et al., 1999; Svensson, Sjöström, & Haljamae, 2000; Tittle & McMillan, 1994; White, 1999).

Therefore, this study focused on the specific strategies that nurses use to assess pain, and explores the impact of the nursing unit as the sociocultural environment of practice on shaping these strategies. The study pursued a novel line of inquiry to develop a descriptive model of the nature of nursing pain assessment in two nursing units.

Guided by Bourdieu's (Bourdieu, 1977, 1984a, 1984b, 1990a, 1990b, 1991, 1998; Bourdieu & Wacquant, 1992) theory of practice, this study described nursing pain assessment in two postoperative nursing units within a large teaching hospital in New England. Bourdieu conceptualizes human practice as a mediation between the individual and the setting in which practice occurs. Three foundational concepts, habitus, capital and field are used to provide a theoretical lens through which to examine the practice of individuals, situated in specific social fields. The study is grounded in the assumption that the specific modalities
that nurses use to assess postoperative clients' pain (the dispositions of their
nursing pain assessment habitus) are profoundly shaped by the field in which they
practice. This is consistent with the findings of work by Foster (1990), Coeling
and Wilcox (1988), and others (NIH, 1994) which suggest that practice is shaped
by the sociocultural context of the specific unit in which it is practiced, and also
builds on Foster's (1990) notion that various aspects of pain assessment and
management are passed on through oral tradition from experienced nurses to less
experienced nurses. It is anticipated, therefore, that the two nursing units will
display different predominating habitus with respect to pain assessment.

In this study, each nursing unit is conceptualized as a field, with its own set
of structured relationships and its own forms of capital. Individual nurses occupy
certain positions in the field vis-à-vis the positions of other nurses, clients,
administrators, physicians and other health care professionals and possess varying
degrees of symbolic capital.

As well, nursing units are also contained within larger 'nursing fields' and
'organizational fields'. It is proposed that each nurse brings a 'nursing habitus'
and more specifically, a 'pain assessment habitus' to each encounter with a
postoperative client. This habitus is the product of the nurses' experience and the
historical experience embedded in the field. The goal of this study was to provide
a description of the structured relationships present in two different fields, two
select nursing units where care is provided for postoperative clients. The nature of
nursing pain assessment habitus will be described, and comparison will be made
between nursing pain assessment habitus in two nursing units. The focus will be on describing individual nurses' pain assessment habitus as exhibited in their practice with postoperative clients and the dominant forms of pain assessment habitus existing in each of the two units as collective habitus.

This study was built around four specific aims:

1. To identify and examine strategies used in pain assessment in order to gain an in-depth understanding of nursing pain assessment habitus framed within Bourdieu's theory of practice.

2. To describe and examine the nature of sociocultural fields of nursing pain assessment practice by mapping out the structural relations within the fields, including the identification and distribution of capital operating in each field, and by comparing specific assessment strategies used in two different settings.

3. To provide a descriptive model of the nature of nursing pain assessment habitus, at both the individual and collective level, as it occurs in two distinct postoperative units.

4. To analyze the predominant collective nursing pain assessment habitus in two distinct postoperative units.

**Research Questions**

In keeping with the general aims described, the study was guided by the following four research questions:
1. What is the nature of the sociocultural field of nursing pain assessment practice in each of two postoperative units?

2. What specific assessment strategies do nurses use in each of these two fields (individual dispositions of the habitus)?

3. What is the predominant nursing pain assessment habitus in each of the two fields?

4. What are the differences in nursing pain assessment habitus between the two fields?

In order to address these research questions, the study applied Bourdieu’s suggested method, reflexive ethnography, in four phases. In addition, a preliminary study to develop an instrument to measure nurses’ pain assessment strategies was conducted.

**Significance for Knowledge Development in the Practice Domain**

Kim (1983, 2000) proposes that phenomena of interest to nursing can be conceptualized as belonging to four theoretical domains: the client domain; the client-nurse domain, the practice domain and the domain of environment. This study is clearly located within the practice domain. For Kim, the concept of practice refers to the cognitive, behavioral and social aspects of professional nursing practice and “encompasses phenomena pertaining to the nurse formulating, thinking about, and contemplating nursing actions as well as those involved in doing nursing, carrying out the work of nursing” (Kim, 2000, p.45).
This study examines one concept of interest to the practice domain, nursing assessment, and more specifically assessment of pain in postoperative clients. Kim (2000) proposes that while there are many phenomena of importance to nursing in the other domains,

it is theoretical development for the domain of practice that is essential in order to make nursing practice scientific. It is with the knowledge of this domain that we can come to a full understanding of how nurses make the difference in clients through nursing practice. (p.128)

This study, and the descriptive model of nursing pain assessment practice presented as a result of this study, represent an attempt to contribute to the development of theory in the practice domain.

The following chapter will present a review of the literature, which places the current study in the context of existing work in the broad arena of pain assessment and of the examination of the social context of practice. Subsequent chapters will describe the theoretical orientation which undergirds the study and method. A detailed description of the methodology is presented for both the preliminary study, which consisted of instrument development, and the principle study, which is the ethnography. Findings from each phase of the study are presented in order. Discussion of the findings is presented. Finally, conclusions and implications for practice, research and education are discussed.
CHAPTER TWO
REVIEW OF THE LITERATURE

This study draws on two broad bases within the existing body of nursing literature, specifically on knowledge related to pain and nurses’ role in the assessment and management of pain, and secondly on the broader body of knowledge related to the examination of nursing practice and clinical decision-making in nursing practice.

The Assessment and Management of Postoperative Pain by Nurses

As previously described, considerable empirical effort has been devoted to nurses’ role in the assessment and management of pain in postoperative clients. Most of the early work focused on the comparison of nurses’ and clients’ perceptions of clients’ pain. Largely, these studies demonstrated that nurses fairly consistently underrated clients’ pain. More recent work in this vein continues to demonstrate similar results (Al-Hassan et al., 1999; Briggs & Dean, 1998; Carr & Thomas, 1997; Field, 1996b).

Inadequately managed postoperative pain has significant costs for both individual clients and for the health care system as a whole. In 1993, the Agency for Health Care Policy and Research (AHCPR) reviewed the findings of a variety of studies on the impact of postoperative pain. They summarized the costs of inadequately managed pain in the following manner:

Pain is just one response to the trauma of surgery, however. In addition to the major stress of surgical trauma and pain, the substances released from
injured tissue evoke "stress hormone" responses in the patient. Such responses promote breakdown of body tissue; increase metabolic rate, blood clotting, and water retention; impair immune function; and trigger a "fight or flight" alarm reaction with autonomic features (e.g., rapid pulse) and negative emotions (Dinarello, 1984; Egdahl, 1959; Kehlet, 1982; Kehlet, Brandt & Rem, 1980). Pain itself may lead to shallow breathing and cough suppression in an attempt to "splint" the injured site, followed by retained pulmonary secretions and pneumonia (Anscombe & Buxton, 1958; Hewlett & Branthwaite, 1975; Latimer, Dickman, Day, Gunn, & Schmidt, 1971; Marshall & Wyche, 1972; Sydow, 1989). Unrelieved pain also may delay the return of normal gastric and bowel function in the postoperative patient (Wattwil, 1989).... In the past, postoperative pain was thought to be inevitable, a harmless though intense discomfort that the patient had to tolerate. Unrelieved pain after surgery or trauma is often unhealthy; fortunately, it is preventable or controllable in an overwhelming majority of cases. Patients have a right to treatment that includes prevention or adequate relief of pain. (AHCPR, 1993, p. 1)

Despite this increasing knowledge of the impact of pain on morbidity, length of stay and prolonged recovery, postoperative clients continue to report experiencing moderate to severe pain (Bostrom, Ramberg, Davis & Fridlund, 1997), receiving inadequate information regarding pain (Carr & Thomas, 1997), and experiencing ineffective pain control (AHCPR, 1992; Berndtsson et al., 1996;
More than 50% of post operative clients report inadequate pain management (AHCPR, 1992). Pain assessment and pain management are poorly documented (Briggs & Dean, 1998; Coyne et al., 1998; Tittle & McMillan, 1994). For example, Briggs and Dean (1998) interviewed sixty-five clients postoperatively about their pain experience, and recorded the client’s worst pain score, as well as their current pain score at time of interview. Nursing documentation of the same clients was transcribed and content analyzed. Their findings revealed that nurses’ documentation of the client’s pain experience differed from the client’s report in almost all instances. In addition, the nurses’ documentation tended to present a ‘diary’ of events related to pain management rather than an evaluation of the client’s pain or the effectiveness of interventions to address pain.

Different and inconsistent methods of assessing pain occur both within and across nursing shifts. In a retrospective study designed to describe the pain management plan of care and pain assessment patterns of nurses, Coyne and colleagues (Coyne et al., 1998) found that nurses used inconsistent methods to rate pain intensity across shifts. No system of pain intensity measure was reported for 40% of the sample, a numerical system was used for 12%, descriptive data were used for 25% and a combination of numeric and descriptive measures were used for 23%. The frequency of assessment as documented also ranged from zero to eight times per shift. Interestingly, in this study, the night shift was most likely to record pain assessment findings.
Despite the dissemination of AHCPG guidelines for pain assessment and management in 1993 (Appendix F) which suggest that the client's self report is the single most accurate assessment criterion, and despite increasing consensus that "pain is what the client says it is", more recent work continues to confirm that nurses frequently use inaccurate assessment criteria (Chuk, 1999; Coyne et al., 1998; Dalton, 1989; Field, 1996a; Francke et al., 1996; Sjöström et al., 2000). For example, using two vignettes presented to nurses describing the pain of hypothetical clients one day after cardiac surgery, Chuk (1999) demonstrated that nurses were more likely to disregard the client’s verbal report of pain unless it was accompanied by elevation in blood pressure and pulse.

Nurses still underestimate client's pain (Al-Hassan et al., 1999; Briggs & Dean, 1998; Field, 1996b; Sjöström, 1995; Sjöström et al., 1999; Sjöström et al., 2000). Field (1996) compared nurses’ and clients’ ratings of pain following spinal surgery in a sample of thirty-nine clients, and seventy-eight nurses who provided care for those same client’s on postoperative days one and four. Nurses and clients were asked to rate the client’s pain at the same moment in time using a five point verbal pain rating scale, ranging from “no pain” to “as much pain as I could possibly bear”. Consistent with findings from a variety of other studies, nurses consistently under-rated client’s pain.

**Client Variables**

A number of studies have also explored variations in the adequacy of pain assessment and management based on client variables. Studies have demonstrated
significant differences in pain management and/or client satisfaction with pain management based on clients’ age (Bell & Reeves, 1999; Lay, Puntillo, Miaskowski, & Wallhagen, 1996b; Ogden Burke & Jerret, 1989). In a sample of 80 clients following either valve replacement or coronary artery bypass surgery, Lay, Puntillo, Miaskowski and Wallhagen (1996) found no significant differences in the doses of opioids provided to clients under sixty-five years of age and those received by clients over sixty-five years. However, Sun, Quinn and Wiessman (1992) reported significant differences in fentanyl dosages in postoperative intensive care unit clients, with clients over sixty years of age receiving significantly less than clients under the age of sixty.

Another study suggests that nurses may perceive the options available to them in pain management differently based on the client’s age group. Burke and Jerret (1989) demonstrated that a sample of student nurses chose different cohorts of interventions strategies for dealing with pain among clients of different age groups. In this study, the participants selected significantly more effective pain interventions as being available for adolescents and adults, and fewer interventions available for use in clients who were either infants or the elderly.

Similar differences in pain management has also been associated with clients’ ethnicity Bell & Reeves, 1999), and medical diagnosis (Fothergill-Bourbonnais & Wilson-Barnett, 1992; Natapoff, 2000; Tittle & McMillan, 1994).
Nurse Variables

In addition to specific variables in the client, a number of studies have attempted to explore variables in the nurse that impact on nurses' assessment and management of postoperative pain (Dalton, 1989b; Dalton et al., 1998; Fothergill-Bourbonnais & Wilson-Barnett, 1992; Nagy, 1998; Warden, Carpenter, & Brockopp, 1998; Wessman & McDonald, 1999). For example, Dalton (1989) demonstrated significant differences in pain assessment practice among nurses who worked in medical surgical settings, and oncology nurses. When asked to describe their first response a client's pain, 43% of the medical surgical nurses and 74% of the oncology nurses reported that they used informal assessment. Forty eight (48) percent of the medical surgical nurses, and 27% of the oncology nurses' first response was some form of treatment. Also, in this study more than two thirds of the nurses indicated that their assessments of a client's pain were influenced by their own beliefs about pain. The ability to generalize from the findings of this study, however, is limited by the use of a convenience sample, and a very small response rate.

The majority of studies that have examined factors affecting assessment of pain address individual factors within the nurse (Dalton, 1989; Wessman & McDonald, 1999). Nurses' ability to assess pain has been correlated with personal attitudes and beliefs (Dalton et al., 1998). Wessman and McDonald demonstrated that nurses' pain management knowledge (as measured by the Nurses Knowledge and Attitude Survey Regarding Pain, (Ferrell, Grant, Ritchey, Ropchan & Rivera,
1993) was associated with their own personal pain experiences. Nurses’ personal pain experiences were negatively related to their pain management knowledge.

Wessman and MacDonald (1999), using a sample of 177 RN’s from a variety of clinical practice specialties in a single medical center in the northeastern US examined the impact of nurses’ personal experience with pain on their assessment and management of clients’ pain. In this study nurses’ personal experience with pain (involving themselves or their family members; and requiring treatment and/or medication), was inversely correlated with pain management knowledge as measured on an instrument (Nurses’ Knowledge and Attitudes Survey Regarding Pain) specifically designed for this study. While noting the difficulty in interpretation necessitated by the use of a correlational design, the researcher hypothesized that these nurses’ pain management knowledge may have been based in their own self-treatment practices (whether effective or not) as opposed to in a body of professional knowledge.

In a study of nurses working in neonatal intensive care units, and burn units, Nagy (1998), demonstrated that nurses’ anxiety regarding client’s pain was associated with four factors, that included: 1) challenges to their images of themselves as alleviators of pain, 2) the degree of personal vulnerability they experienced by contact with clients in severe pain 3) their beliefs about their efficacy and ability to adequately assess clients’ pain, and 4) the quality of their professional relationships with physicians. In this study, nurses in both clinical
specialties described their belief that they had failed as nurses when clients suffered unnecessary pain.

Franke, Lemmens, Abu-Saad and Grypdonck (1996) used participant observation and qualitative interviews with a group of Dutch surgical cancer nurses to conduct a needs assessment regarding pain management. Their findings demonstrated that nurses failed to assess pain systematically, gave insufficient doses of analgesics, were unaware of the effectiveness of - and failed to use - nonpharmacological techniques for pain management. The same researchers (Francke, Lemmens, Abu-Saad, & Grypdonck, 1997) also identified factors that influenced the use of knowledge gained in a pain management program in a sample of surgical nurses from a number of general hospitals. These factors included the degree of congruence between the program’s philosophy, and the nurse’s personal philosophy of pain management, general attitudes toward the program, attitudes toward innovation in general, and the nurses’ self-efficacy.

The ability to apply findings from the current literature is hindered by some common limitations. One is that many studies to date focus on the use of either simulated or hypothetical situations, as opposed to actual nursing practice. Also, a number of studies rely on nurses’ retrospective analysis of their conduct in client care situations. Another significant limitation in the existing literature is the failure to distinguish between nurses’ assessment of pain, and nurses’ management of pain. Most studies examined for this review describe nursing assessment and management of pain as if they represent one process. It seems appropriate to
assume that, at least analytically, assessment and management represent two
different decision-making points in nursing practice and that adequate
management of pain is unlikely in the absence of adequate assessment.
Interpretation of the existing literature is hindered by the failure to address this
distinction.

In addition, the studies which suggest that client or nurse characteristics
have some influence on pain assessment or management do not clarify through
what mechanisms or processes such factors influence pain assessment and/or
management at either the individual or collective levels.

Pain Assessment Strategies

Few studies address the specific strategies that nurses use in practice to
assess pain in postoperative clients. Natapoff (2000), in the conduct of a
multinational study designed to compare nurses’ and family members’ assessment
of pain across three groups of clients (laboring women, children and the elderly),
also included a content analysis component that identified basic strategies that
families and nurses used to assess clients’ pain. The analysis produced two broad
themes, indicating that nurses “saw” pain through client’s facial expressions,
posturing, gestures as well as “seeing” pain in the use of technological aids, like
vital sign or fetal monitoring, and that nurses “heard” pain through verbal
complaints, moaning or crying. However, the researcher did not attempt to study
more specifically the strategies that nurses used to assess clients’ pain, nor did the
study address strategies that nurses use in postoperative pain assessment.
Studies by Sjöström and colleagues (Sjöström, 1995; Sjöström et al., 1999; Kim & Sjöström, 2000) represent the most detailed attempts to explore specific strategies that nurses use to assess postoperative pain. Using a phenomenographic approach in a number of settings, the researchers developed a typology of eight categories, under two broad themes. The first theme, criteria, includes four different types of approaches that nurses used to assess pain in postoperative clients: *how the client looks, what the client says, the client’s way of talking, and experience of similar circumstances*. The second broad theme addresses the impact of experience in shaping the strategies that nurses use to assess pain. These categories were corroborated in a subsequent sample (Sjöström et al., 1999) and in a set of cross-national studies (Chang, Kim, Sjostrom & Schwartz-Barcott, 2001; Kim & Sjöström, 2000). In these studies, the four strategies described by nurses as what they have learned regarding pain assessment from experience reveal four divergent approaches to the assessment of pain in postoperative clients. The first, *I have learned a typology of clients*, refers to the development of models which can be used to assess a standardized group of clients. The typologies described by the nurses included the type of surgery, the type and duration of anesthesia, previous experience with analgesics in this group of clients, etc. The second strategy, *I have learned to listen to the clients*, emphasizes the subjective nature of pain. Here, the nurse perceives the client’s perspective as the critical factor in assessing pain. The third category, *I have learned what to look for*, describes the role of experience in focusing the nurse to attend to particular criteria for the assessment
of pain. The final category, *I have learned what to do for the client*, represents an approach that sees assessment as inseparable from treatment of pain, and focuses on the utility of experience in selecting the appropriate approach for management of pain. For the nurses in these studies, experience was a major influence on the strategies they chose to assess and manage pain in postoperative clients. However, it must be noted that experience taught different nurses within these samples very different strategies. What remains to be explored are the mechanisms by which experience shapes nurses’ choices with respect to pain assessment. So far, no published studies have directly addressed the role of experience, in particular the sociocultural setting in which nursing is practiced in shaping nurses’ assessment strategies.

**The Practice Domain as a Focus of Inquiry**

In addition to its use of Bourdieu’s theory of practice, the proposed study is also uniquely situated with respect to the universe of nursing knowledge. Kim (1987, 2000) proposes a typology of theoretical domains for nursing, which includes the client domain, the client-nurse domain, the practice domain and the domain of environment, and suggests that knowledge relative to each of these domains is necessary to address the broad array of phenomena of interest to nursing. While the explanandum of a particular object of theoretical development, or a concept of interest for empirical study, is proposed to rest in one of the four specified domains, this approach is undergirded by the presupposition that the roots of all phenomena of interest to nursing are in the client. The typology
provides recognition of the vast diversity of phenomena of interest for nursing scholarship

Kim’s domains serve as an analytic tool designed to adequately locate phenomena of interest, and also directs the nurse-scientist to a particular lens with which to conduct empirical examination or to approach theoretical development.

As Kim has described, the practice domain is conceptualized to include phenomena particular to the nurse who is engaged in delivering nursing care. Central to an understanding of the practice domain is Kim’s conceptualization of nursing practice as “the cognitive, behavioral, social and ethical aspects of professional actions and activities performed and/or experienced by nurses in relation to nursing care” (Kim, 2000). This recognition of practice as something broader than simply what the nurse does with or for the client, and which recognizes that there are cognitive, behavioral and social aspects of practice is consistent with Bourdieu’s theory of practice which suggests that there are significant preconscious, historical, and social influences on the practice of the individual, and is different from earlier conceptualizations of practice which suggest that the act of practice is simply a direct application of the professional’s knowledge (Kim, 2000).

Kim’s conceptualization of nursing practice includes both mental and behavioral aspects of practice, which she suggests can be viewed as occurring within two dimensions: the deliberation dimension (including processes such as assessment, judgment, and decision-making) the nurse and the enactment
dimension (including what the nurse actually does as a result of deliberation). Kim suggests that systematic study of concepts within the practice domain is essential to the development of an effective science for nursing. This conceptualization of nursing practice would be seen as substantially different from that proposed by Benner and colleagues (Benner, 1984; Benner, Tanner, & Chesla, 1996; Benner & Wrubel, 1989) who propose a process that is more intuitively based and involves nursing action as the response to an intuitive apprehension of the demands inherent in a particular nursing care situation. What is similar between the two approaches, however, is that Kim also proposes that the deliberation phase is not always a conscious process, but under some circumstances it may be. For Benner, the practice of the expert nurse almost never includes a conscious, deliberative process of assessment or judgment. These dimensions are viewed separately for analytic purposes, but are presumed to overlap and blur in actual practice.

Kim proposes that “effectiveness of nursing practice depends on an understanding of how nurses think, make decisions, transfer knowledge into actions, or use available knowledge (both universal and personal) in actual practice” (Kim, 1987).

To date, those studies that have addressed nurse’ management of clients’ pain have largely focused on knowledge in the client domain, or the client–nurse domain. This study proposes to examine the phenomena of nurses’ assessment of pain, which is clearly located within the practice domain. It is anticipated that the
study will provide a descriptive framework of nurses’ pain assessment habitus. Kim (1994) proposes that development of theory within the practice domain is essential to the ongoing development of nursing knowledge. The proposed study is guided by the dimension of nurse-agent described by Kim (1994), and is, therefore “viewed with the focus on the nurse as an agent of action” (p.149). Kim’s description of the phases of deliberation and enactment by the nurse-agent in action may initially appear to conflict with the relational nature Bourdieu’s theory of practice, however Kim emphasizes that her conceptualization of phases of deliberation and enactment is an analytic tool, and is, like Bourdieu’s theory, not intended to provide a model of reality, but rather a tool for the examination of nursing practice in action. In her conceptualization of these two phases of nursing practice, Kim (2000) envisions the context of practice as one of the major frames that impacts on the nature of what goes on in both nurses’ deliberations and enactment. This framework conceptualizes the settings of practice (the field) as important frames where mediations take place among the nurse’s belief systems, goals, their plans for the current situation and the nature of the practice setting itself.

**Decision-Making in Nursing Practice**

Pain assessment is framed within the larger context of decision-making in nursing practice. Each aspect of assessment involves the process of clinical decision-making. Nurses decide what cues to attend to, what cues will be perceived as significant, which will be determined to be indicative of pain, and
how these will be categorized or prioritized to provide an understanding of the client’s type and severity of discomfort. Further, nurses’ choice of strategies to address clients’ pain involve a complex process of decision-making. Nurses’ decision-making regarding the available options for assessment and management of pain are limited by the options they perceive as available in the environment, and those options which nurses believe will have a high likelihood of success in relieving pain, while minimizing potential negative effects. It is reasonable to propose that both aspects of this process (the cues that will be perceived as significant and the potential options available for intervention) are shaped within the practice setting, and may vary from nursing unit to nursing unit.

Ferrell et al. (1991) apply a model of decision-making to examine nurses’ pain assessment and management. While the researchers present a number of decision points that nurses face in their treatment of pain, the model presented does not distinguish between the processes of pain assessment and pain management. They did, however, identify eight strategies that nurses used to assess the intensity of clients’ pain including: the client’s verbal report of pain, observing the client’s mobility/activity, observing the client’s behavior, information from family/caregivers, verbal information from other nurses, other nurses’ documentation, physician’s notes/records, and “other” sources of information. In this study, the most frequently used method to assess the intensity of pain was asking the client (used by 91% of nurses), but only 45% of the nurses
considered this to be the most influential factor in their decision making regarding the intensity of the client's pain. Only 59% of nurses used a pain-rating scale.

Conceptualizations of clinical decision-making have been proposed to fall within two broad theoretical approaches (Thompson, 1991). The systematic-postivistic approach is characterized by conceptualizations of decision-making consistent with the hypothetico-deductive model, and other rational approaches. Decision-making is conceived as a series of rational steps conducted in a linear fashion. The practitioner gathers preliminary clinical information regarding a client in a given encounter, and from this information generates tentative diagnostic hypotheses. He/she then interprets the ongoing cues gathered during assessment as either confirming, refuting, or irrelevant to the initial hypotheses. Finally, the practitioner evaluates the pros and cons of each possible decision alternative and chooses the one most consistent with the majority of the available data. Alternatively, the intuitive-humanistic approach is exemplified by the work of Benner and colleagues. Here, action is viewed as preceding analytical thought. Harbison (1991) suggested that this approach is more consistent with the actual processes of decision-making used by experts in clinical practice.

The utility of studying practice using each of these approaches has been widely debated in the nursing literature. Farrell, Ebets, McCaffery and Grant (1991) provide a concise analysis of the contributions of each of these theoretical positions to current understanding of decision-making in nursing practice. However, what both views fail to identify is the specific role that the sociocultural
environment plays in decision-making. That is, decision-making in nursing practice, while it is an individual, cognitive/experiential process, needs to be viewed in terms of the context within which such processes take place as there is evidence that decision-making is also impacted by extra-cognitive forces.

There is evidence to suggest that nurses within different contexts use vastly different decision-making processes (Lauri & Salanter, 1998; Lauri et al., 1997). While a growing number of studies have concluded that the practice environment has a significant impact on how nurses assess and manage client’s pain (Francke et al., 1997; Price & Cheek, 1996; Scheller, 1993), there is no existing empirical base that describes the process by which the sociocultural environment shapes nurses’ decision-making in this area. Interventions designed to improve the process of pain assessment and management are less likely to be successful unless they are grounded in knowledge of this process.

**Pain Assessment as Social Practice**

The majority of studies related to nurses’ assessment of postoperative pain have focused on variables within the client-nurse dyad. This approach neglects the knowledge that nursing practice does not occur in isolation, and that the sociocultural field of nursing practice impacts on the practice of the individual nurse.

Cervero (1985) describes the nature of the practice environment as a substantial barrier to the implementation of innovation and knowledge utilization in practice. She states: “the social system in which a behavior change must
actually be implemented may be the most powerful yet overlooked variable in analyzing the effectiveness of continuing professional education” (p. 116).

Price and Cheek (1996) propose that pain management and views of what constitutes appropriate pain assessment and management are influenced by profoundly political aspects of practice. This analysis is consistent with the findings of a study comparing the knowledge of pain between nurses in hospice settings and nurses in intensive care settings (Fothergill-Bourbonnais & Wilson-Barnett, 1992), where nurses in both groups identified the working environment and their clinical experience as their most influential experiences contributing to their knowledge of pain and its assessment (Fothergill-Bourbonnais & Wilson-Barnett, 1992).

Other studies have suggested that the social setting in which nurses practice can serve as a barrier to the implementation of new learning in practice. Czurylo, Gattuso, Epsom, Ryan and Stark (1999) assessed knowledge gain, changes in practice, and barriers to implementation of knowledge in practice in a group of staff nurses attending a pain management education program. In this study, despite significant knowledge gain as a result of the program, nurses described barriers to implementation of new knowledge regarding pain management including “the people with whom I work”, “the setting or department” and “working with physicians”. However, the findings of this study should be interpreted with caution given the very low response rate (27%) identified by the authors.
Several studies have suggested that there are poorly understood forces within
the client care environment that shape nurses' practice with regard to pain
assessment and pain management (Foster, 1990; Francke, Lemmens, Abu-Saad, &
Grypdonck, 1997; Kim & Sjöström, 2000; Price & Pooler-Lunse, 1996; Wild &
Mitchell, 2000). A number of studies have cited the practice environment itself as
a major barrier to adequate pain management in nursing (Czurylo, Gattuso,
Epsom, & Stark, 1999; Dalton et al., 1998; Francke et al., 1997; Nash et al., 1999;

In 1994, the report of the NINR (at that time NCNR) Priority Expert Panel:
Symptom Management – Acute Pain (NIH, 1994) provided a state of the science
report on empirical work in nursing management of clients in acute pain. The
report suggested that there was a need to better understand unit level influences on
the practice of individual nurses with respect to pain assessment and management.
The panel cited the findings of a number of studies that attempted to identify
contextual factors that impact on nursing practice. For example, Coeling and
Wilcox (1988) identified significant variation in culture between two nursing units
on a number of themes, including change and following established standards.
They propose that knowledge of specific unit culture may be essential to
development of an adequate understanding of nurses' attitudes and behaviors.

Foster (1990) proposes that different unit cultures exist within an
organization, and that differences may influence the priority given to pain
assessment and management activities. She suggests that the most influential pain
assessment guidelines are informal standards which are passed from more experienced nurses to less experienced nurses as oral history. The NINR panel recommended that future efforts toward an understanding of pain management in the postoperative period needed to address the impact of context. "The relevance of contextual variables to client outcomes is being recognized (Coeling & Wilcox, 1988; del Bueno & Vincent, 1986; Miller, 1987;) and this recognition needs to be extended to pain management" (NIH, 1994, p.14). Further, one of the recommendations for future study was to "determine the effects of informal unit standards that guide pain management practices on clinical units" (p. 15).

The work of Benner and colleagues (Benner, 1984; Benner et al., 1996; Benner & Wrubel, 1989) has heightened awareness of the development of expertise which occurs in practice. However, this process of development does not occur in isolation from the cultural norms, rules and routines in a particular area of practice. Taylor (1997) proposes that socialization within a particular unit culture is a critical stage of novice nurse development. Greenwood (1993) proposes that the development of "routines" for certain client populations are idiosyncratic, and that students and new staff become habituated to the 'typical practices' present in the social setting, regardless of their impact as caring practices or their effectiveness.

Perhaps the most widely read empirical work that addresses the sociocultural context of practice with respect to pain management is Fagerhaugh & Strauss' (1977) "The Politics of Pain Management", which also arises from the
ethnographic tradition. This work focused broadly on organizational and political issues surrounding pain management. Nursing practice was not a specific focus of the researchers’ work. The proposed study intends to move from Strauss’ broad exploration of the nursing unit as a whole, to a study aimed at understanding the practice of the individual practitioner as situated within the field of practice. Secondly, while Fagerhaugh and Strauss were principally interested in understanding the behavior of the organization as an entity, this study will focus on a more detailed and micro-level analysis of the assessment process, and specifically how individual nurses pain assessment habitus is both shaped by and helps to shape (as Bourdieu would describe – structures and is structured by) the collective habitus of nurses in the field.

One recent study highlights the importance of the nursing unit as a factor in shaping the pain management strategies used by nurses, and raises important questions for further study. Wild and Mitchell (2000) examined the relationship between pain outcomes and the specific unit in which nursing practice occurs. This comparative study was designed to explore the impact of the organization, as the context of care, on pain management, and demonstrated that pain management outcomes (as measured by total pain intensity, satisfaction with pain management and perceived quality of pain management practices) were associated with the following contextual variables: nursing attitudes supportive of aggressive pain management, nurses conducting discussions regarding pain management, coordination of pain-relieving care with other nurses, and higher levels of nurse
discretion regarding pain management. The researchers propose "results from this study suggest that attitudes about pain, pain management, and the goals of therapy may extend to the group or unit level, thereby creating a type of 'group-think' about pain management issues" (p. 141). These findings support the notion drawn from Bourdieu's theory of practice, that factors specific to the environment influence how nursing is practiced. Unfortunately one of the limitations of this study is that it compares three units that provide care to very different client populations (orthopedic clients, oncology clients and critical care clients). These differences make it difficult to separate differences in pain assessment and management which are based in differences in the unit culture, and differences based in differences in the clients themselves. Secondly, the study relies solely on nurses' self-report of their assessment and management practices. The findings do, however, lend credibility to the notion that certain characteristics of the nursing unit affect the practice of individual nurses. Use of an ethnographic design in two units will extend this work in two ways. First, participant observation will allow the researcher access to nurses assessment strategies as they occur in real-time practice situations. Secondly, ethnographic examination of the nature of the field of nursing practice, and comparison across two different fields will allow for more specific analysis of the factors within the unit that shape the nurses' practice.
Summary

Postoperative pain remains a significant concern in nursing practice.

Inadequate management of postoperative pain is associated with the development of additional postoperative complications, adds to client morbidity, prolongs length of hospital stay and delays return to activities of daily living. Despite recent advances in knowledge of pain management, evidence suggests that management of postoperative pain remains less than adequate. This study intends to build upon the work done to date in two ways. First, the studies described above have demonstrated that nursing pain assessment practice is influenced by the environment in which they practice. Nurses’ work in acute care settings is carried out in a unit-oriented environment. The nursing units are the immediate sociocultural fields of practice in which nurses learn, internalize and incorporate social norms of practice (Fagerhaugh & Strauss, 1977). It is within the context of the nursing unit (field) that practice norms, protocols and routines (what Bourdieu would call sociocultural habitus) is formed. To date, no published work has specifically examined the role that the nursing unit (as field) plays in shaping the pain assessment practice of the individual nurse. Different nursing units also have different sociocultural conditions and influences. No studies have examined the difference in pain assessment practices between different units (different fields). What these studies have provided is an assessment of variables within the unit environment that impact nurses pain assessment practice. For example, Scheller’s (1993) typology of environmental factors that impact nurses’ practice, and the
environmental factors noted by Francke et al (1997) provide direction for the analysis of relations within the field. Analysis of the fields used in this study will be guided by the contextual variables presented in these studies.

What these studies have done well is describe variables in the environment that may have an impact on nurses' practice. This study aimed to describe the mechanisms by which these variables have their impact. Interventions designed to improve the process of pain assessment and management are unlikely to be successful unless they are grounded in knowledge of this process. Therefore, the current study sought to provide a descriptive model of the role that the sociocultural context in which practice occurs plays in shaping the individual nurse's decision-making. This study attempted to provide an understanding of how nurses' decisions regarding pain assessment are shaped within the context of the practice environment. It is believed that this knowledge will assist in the design of interventions to improve nurses' assessment and subsequent management of pain. This is based on the premise that nurses' practice, including nursing assessment, cannot be understood or explained fully from the cognitive, behavioral, or phenomenological perspectives only, as these perspectives do not consider the field of practice as having a penetrating impact on practice. This study, therefore, attempted to address this gap by providing a descriptive model of the nature of nursing pain assessment habitus in two different settings. The knowledge gained from this study will help to shape the design of future interventions to improve the management of pain in postoperative clients.
CHAPTER THREE
THEORETICAL ORIENTATION

Bourdieu's Theory of Practice

The proposed study is guided by Pierre Bourdieu's theory of practice (Bourdieu, 1977, 1984a, 1984b, 1990a, 1990b, 1991, 1998; Bourdieu & Wacquant, 1992). Bourdieu's work has been widely influential in the social sciences in Europe since the 1950's. His theory of practice has been extensively used in Europe, and has guided studies of education, language, kinship structures, matrimonial strategies, the culture of academia, and others. His work has more recently been influential in North American sociology and education. To date, only one published study in the English-language nursing literature describes the use of Bourdieu's theory to guide research (Sidenvall, 1999).

Bourdieu's work has variously been described as a philosophical perspective (Grenfell & James, 1998), a practical methodology (Grenfell & James, 1998), a philosophy of social science (Bourdieu, 1998), and a philosophy of action (Bourdieu, 1998). However, there is general agreement that one segment of Bourdieu's work, (especially as presented in Bourdieu, 1977; Bourdieu, 1990; Bourdieu, 1991; Bourdieu, 1998; Bourdieu & Wacquant, 1992) represents most closely a grand theory of practice.

Bourdieu's work is both wide-ranging and complex. His own studies have focused on subject matter as diverse as education, art, language, sport, politics, the media, matrimonial practices and kinship affiliation. Because of his broad range
of study, and because his work weaves theoretical and empirical acts together in such a way that they are indistinguishable from one another, one does not find a neatly packaged theoretical structure that lends itself easily to description or analysis.

Bourdieu’s academic origins are rooted in Parisian thought of the 1950’s and 60’s. Initially, his work was framed within the structuralist perspective, particularly the work of Lévi-Strauss and colleagues. From this perspective, the actions of agents are largely determined by structural issues within the social space. Bourdieu’s early ethnographic work was consistent with this philosophical perspective, but over time, he became increasingly disenchanted with the deterministic view of human agents as ‘rule-following’ espoused by this perspective.

Bourdieu proposes that objectivist approaches to knowledge development (particularly as characterized by structuralist approaches) are inadequate because they fail to recognize the unique perspective that agents bring to their practice, they ignore the generative nature of individual’s action and their ability to apprehend possibilities in all situations, and reduce the actions of actors, such that, ...

...the practical activities of individuals can appear as nothing other than the application of a rule, or the realization of a model or structure, which has been elucidated or constructed by the analyst. Practice is turned into a mere epiphenomenon of the analyst’s own construct. (Thompson, 1991, p. 12)
Bourdieu's critique is not limited solely to the so-called 'objectivist' approaches to knowledge development. Similarly, he rejected the pure subjectivist approach advocated by the other predominant French perspectives of the 1950's and 60's exemplified by the phenomenology of Merleau-Ponty and the existentialism of Sartre.

He is especially critical of these 'subjectivist' approaches, as characterized by interpretivist or phenomenological thought. From Bourdieu's perspective, these approaches neglect the objective structures that surround human practice. For Bourdieu, the context, or field within which practice occurs has to itself an objective structure that is more than what can be perceived simply from the perspective of the actor. From a purely subjectivist perspective, the context or field of practice is relevant only insofar as the actor's perception of it. For Bourdieu, human practice involves a two-way relation between the "the subjectivist apprehension of the player and the underlying, objective configuration of rules of the game played" (Wacquant, 1992, p. 23)

Subjectivist approaches, as characterized by phenomenology and existentialism make two assumptions that Bourdieu conceives as inadequate (Thompson, 1991). The first is that it is somehow possible to develop an understanding of the lived experience of others. The second is that agents' perception of the social world represent an accurate account of it.

The opposing nature of these two perspectives, and Bourdieu's criticism of each, is central to the development of Bourdieu's own perspective. Wacquant
(1992) argues that Bourdieu’s approach to recognizing and dispelling these perceived divisions forms the logical assumptions that undergird his theoretical work, and that Bourdieu’s approach “effectively welds phenomenological and structural approaches into an integrate, epistemologically coherent, mode of social inquiry of universal applicability” (p. 4).

Bourdieu’s approach to knowledge generation, therefore, seeks to blend elements of both subjective and objective accounts of practice in order to describe practice more fully. He suggests that it is necessary to “move beyond objectivism, without relapsing into subjectivism, that is, to take account of the need to break with immediate experience while at the same time doing justice to the practical character of social life” (Thompson, 1991, p. 12).

Primarily, Bourdieu’s theory represents an attempt to move beyond previous philosophical points of view in the social sciences, and to bridge what have been widely perceived and seemingly irresolvable dichotomies in the social sciences. Bourdieu believes that these divisions are false, and that the perception of them obscures the development of our understanding of social practice. The key to understanding Bourdieu’s work and in understanding the coherence of his logic rests in an understanding of his perception of the social universe. In Bourdieu’s view, structures within the social universe:

Exist twice: in the ‘objectivity of the first order’ constituted by the distributions of material resources and means of appropriation of socially scarce goods and values… and in the “objectivity of the second order” in
the form of systems of *classification*, the mental and bodily schemata that function as *symbolic* templates for the practical activities – conduct, thoughts, feelings and judgments – of social agents. Social facts are objects which are also the object of knowledge within reality itself because human beings make meaningful the world which makes them. (Wacquant, 1992 p. 7)

**The Theory of Practice**

In the theory of practice, Bourdieu presents a *relational* theory of practice as human action that describes the practice of individuals, situated within structured social fields, using three foundational concepts field, capital and habitus. For Bourdieu, each instance of human practice is a mediation between structures within the individual (individual habitus) and structures within the context of practice, conceptualized as field.

**Major concepts**

Bourdieu constructs his comprehensive theory of practice around three foundational concepts: *field, capital and habitus*. While some analysts have treated Bourdieu’s use of terms associated with other work (specifically habitus, from Aristotelian thought, and capital from Marx), as derived concepts, Bourdieu (Bourdieu & Wacquant, 1992b) warns against this perspective.

To treat theory as a *modus operandi* which practically guides and structures scientific practice obviously implies that we give up the somewhat fetishistic accommodativeness that “theoreticians” usually establish with it.
It is for this reason that I never felt the urge to retrace the genealogy of the concepts I have coined or reactivated, like those of habitus, field, or symbolic capital. Not having been born of theoretical parthenogenesis, these concepts do not gain much by being resituated vis-à-vis previous usages. Their construction and use emerged in the practicalities of the research enterprise, and it is in this context that they must be evaluated. (p. 161, emphasis added)

Bourdieu describes each of the three foundational concepts of his theory of practice as having been borne out of the analysis of empirical data. Again, in Bourdieu’s words:

The function of the concepts I employ is first and foremost to designate, in a kind of shorthand, within the research procedure, a theoretical stance, a principle of methodological choice, negative as well as positive.

Systematization necessarily comes ex post, as fruitful analogies emerge little by little, as the useful properties of the concept are successfully tried and tested. (Bourdieu & Wacquant, 1992b, p. 161)

Field

The first of Bourdieu’s foundational concepts is field. Bourdieu uses the concept of field to describe the social context of action. A field is the social space within which agents practice, and represents a structured system of social relations. Bourdieu (cited in Grenfell & James, 1998) states:
I define field as a network, or a configuration, of objective relations between positions objectively defined, in their existence and in the determinations they impose upon their occupants, agents or institutions, by their present and potential situation (situs) in the structure of the distribution of species of power (or capital) whose possession commands access to the specific profits that are at stake in the field, as well as by their objective relation to other positions (domination, subordination, homology, etc). (p. 16)

As Grenfell and James (1998) describe a field is “a structured system of social relations at a micro and macro level. In other words, individuals, institutions and groupings, both large and small, all exist in structural relation to each other in some way” (p.16). Further, they suggest, “if habitus brings into focus the subjective end of the equation, field focuses on the objective” (p. 15).

Agents assume particular structured positions within the field. “The position of a particular agent is the result of an interplay between that person’s habitus and a field of positions as defined by the distribution of the appropriate form of capital” (Postone et al., 1993, p. 5).

Each field is conceptualized as being semi-autonomous, and is characterized by its history, the nature of its agents, its own logic of action and its own forms of capital (Postone et al., 1993). However, similar fields are also related to each other, and are located within even larger institutional fields.

Practice is conceptualized as the product of the relationship between a particular habitus and a particular field. Bourdieu likens the response of a habitus
to the field in which it was developed as “a fish in water”. In effect, the habitus functions more comfortably and seamlessly in its own ‘home’. The reverse also applies:

Practices should be seen as the product of an encounter between a habitus and a field which are, to varying degrees, ‘compatible’ or ‘congruent’ with one another, in such a way that, on occasions when there is a lack of congruence (e.g. a student from a working class background who finds himself or herself in an elite educational establishment), an individual may not know how to act and may literally be lost for words. (Thompson, 1991, p. 16)

While the structures of the field serve to provide an understanding of the objective nature of reality, they are not fixed. As Turner (1998) describes,

Such structures constrain and circumscribe volition, but at the same time, people use their capacities for thought, reflection, and action to construct social and cultural phenomenon. They do so within the parameters of existing structures. These structures are not rigid constraints, but, rather, materials for a wide variety of social and cultural constructions (p. 509).

A field is “simultaneously a space of conflict and competition” (Wacquant, 1992, p.17). Thus, a field is conceptualized as the setting in which practice occurs and also the setting in which agents assume certain structured positions, and attempt to alter their position through the acquisition of capital, or alternatively to preserve their position through maintenance of the status quo. In this respect,
Bourdieu’s concept of field is dissimilar to more general conceptualizations of environment or context. For Bourdieu, the field is a location in the social space where individuals are located for practice in a sustained engagement, which is different from other conceptualizations which view the environment as a locale, which has an impact on practice which may be temporary or fleeting. For Bourdieu, field is conceived as having a penetrating impact on the practice of the individual. As a set of structured relations, the field both shapes and constrains the practice of the individual. Relations in the specific field help to define the specific practice acts which are acceptable, practical and rewarded within the field. These relations are expected to differ from field to field.

**Capital**

The next of Bourdieu’s key concepts is capital. Bourdieu (1998) describes a variety of types of capital, including economic, cultural, symbolic, informational, social, academic and political capital. Capital represents power over a field, and the actions of agents. Currency is an obvious example of economic capital, but other types of capital operating in a particular field may be less apparent.

Capital is the mechanism that allows one to exercise control over one’s own life and that of others. The possession of capital determines one’s place within a field. Grenfell and James (1998) describe capital as “the social products of a field or system of relations through which individuals carry out social intercourse” (p. 18). In each field, “participants vie to establish monopoly over the species of capital effective in it” (Wacquant, 1992, p. 17).
The concept of capital is also more broadly associated with social class. Postone, LiPuma and Calhoun (1993) propose:

This notion of capital also serves to theoretically mediate individual and society. One level, society is structured by the differential distribution of capital, according to Bourdieu. On another level, individuals strive to maximize their capital... The capital that they are able to accumulate defines their social trajectory... moreover, it also serves to reproduce class distinctions. (Postone et al., 1993, p. 5)

Capital, however, is not a static product of the system, with unchanging value. The value of any particular type of capital varies between fields, and within a given field, over time. The value of various forms of capital within a field is open to change and evolution, and capital is not of value in and of itself, but only in terms of its practical consequences within the field (Grenfell & James, 1998).

Habitus

The final foundational concept, and that of primary interest is this study, is habitus, defined as “systems of durable, transposable dispositions, structured structures predisposed to function as structuring structures, that is, as principles which generate and organize practices” (Bourdieu, 1990b, p. 53). First, as systems of dispositions, the habitus inclines agents to act in particular ways. “The dispositions generate practices, perceptions and attitudes which are ‘regular’, without being consciously co-ordinated or governed by any rule” (Thompson, 1991, p. 12). These dispositions are acquired by the individual through a process
of inculcation. Individuals are exposed, through processes that are both visible
and less obvious, to those actions and practices that are seen as available and
acceptable, and those likely to be perceived as successful. These inclinations to
act in particular ways become second nature over time (Thompson, 1991, p. 12).
Furthermore, the habitus is “constructed in practice and is always oriented to
practical action” (Bourdieu, 1990, p. 52).

The dispositions of the habitus are *structuring* in that they give shape to the
practice of the individual, but they are also *structured* in that they necessarily
reflect the nature of the social conditions in which they were developed (Bourdieu,
1990; Thompson, 1991). Bourdieu (1990) emphasizes that the habitus gives
disproportionate weight to early experience, and describes the dispositions of the
habitus as ‘embodied history’. Therefore, it is reasonable to assume that those
agents who are the products of the same social fields will have dispositions that are
similar in many respects (Bourdieu, 1990b). The dispositions of the habitus are
durable, in that they “endure through the life history of the individual, operating in
a way that is pre-conscious and hence not readily amenable to conscious reflection
and modification” (Thompson, 1991, p. 13). Enactment of the dispositions of the
habitus is not necessarily logical or deliberative. Bourdieu suggests that, practice
entails only that degree of logic that is required of it. Finally, the dispositions of
the habitus are conceptualized as being generative (capable of generating new or
revised practices) and transposable (capable of continuing to operate, even in
fields other than that in which they were generated).
For Bourdieu, the concept of habitus provides a clear departure from Lévi-Straussian structuralism. Agents are seen not simply as rule-following, but as mediating and capable of generating new practices, in essence, capable of both rule-following and rule-making in practice. The habitus does, however, also serve to perpetuate certain ways of responding and certain practices. The habitus, therefore, is conceived as continuously mediating between ‘practical sense’ gained through history and unique demands present in the immediate situation. The habitus is “the dynamic intersection of structure and action, society and the individual” (Postone, LiPuma, & Calhoun, 1993, p. 4). The habitus is capable of the generation of new ways of acting, but not infinitely so. As Wacquant (1992) describes, “habitus is creative, inventive, but within the limits of its structures, which are embodied sedimentation of the social structures which produced it” (p.19). Bourdieu describes the stability of the dispositions of the habitus in this way:

The habitus, a product of history, produces individual and collective practices – more history – in accordance with the schemes generated by history. It ensures the active presence of past experiences, which, deposited in each organism in the form of schemes of perception, thought and action, tend to guarantee the ‘correctness’ of practices and their constancy over time more reliably than all formal rules and explicit norms. (Bourdieu, 1990, p.54)
Habitus, then, is a series of dispositions to behave in certain ways, to respond in certain ways, to prefer certain goods to others, even to move and carry oneself in certain ways. Habitus is inculcated through repeated exposure to regular forms of practice present in one’s social field. It is, in essence, how agents both learn and perpetuate what are the ‘usual’ and ‘acceptable’ ways to conduct oneself. Habitus is social inheritance (Grenfell & James, 1998, p. 14). The dispositions of the habitus are durable, and tend to perpetuate themselves through activation in the social field. However, it must be emphasized that the dispositions of the habitus are not ‘rules’ and do not determine behavior in all situations. Habitus, and in particular the generative nature of the habitus “gives any field a historical dynamism and malleability that avoids the inflexible determinism of classical structuralism” (Wacquant, 1992, p. 17). “The habitus is self-reflexive in that, each time is animated in practice, it encounters itself, both as embodied and as objectified history” (Postone et al., 1993 p. 6).

Those agents with similar histories in similar fields possess similar dispositions of the habitus. Turner (1998) suggests that “in a sense, habitus is the ‘collective unconscious’ of those in similar positions because it provides cognitive and emotional guidelines that enable individuals to represent the world in common ways and to classify, choose, evaluate, and act in a particular manner” (p. 515).

Bourdieu frequently uses the analogy of sport to illustrate the nature of the habitus. Habitus is likened to the player’s ability to develop ‘a feel for the game’. This ‘practical sense’ is neither simply a rote application of the rules of the game,
nor an objective assessment of possibilities for action. Rather, it is a *preconscious* apprehension of all of the potential possibilities inherent in the game. In the same way, the habitus operates largely at a preconscious level. As embodied history, the ‘practical logic’ demonstrated by the actions of the habitus does not require, nor does it encourage conscious reflection on action.

**Relational Statements**

Bourdieu’s theory of practice does not consist of a series of clearly defined theoretical propositions. Wacquant (1992) notes that while Bourdieu is widely considered to be a social theorist his work rarely contains theoretical statements or arguments. Instead, Bourdieu presents explication of the relationships between concepts as research issues or problems that arose while in the process of analyzing data, or while thinking through a substantive issue. Wacquant (1992) suggests that Bourdieu’s writings “amplest testify that he is not inimical to theoretical work. What he stands poised against is theoretical work done for it’s own sake, or the *institution* of theory as a separate, self-enclosed, and self-referential realm of discourse” (p. 30). From this perspective, the development of fixed relational statements and enduring theoretical propositions does not add to the understanding of practice. Rather, by attempting to view practice in a purely objective manner, theoretician theory is reductionist in that it ‘fixes’ the agents and their actions in a particular point in time, and it ignores the creativity inherent in their actions. As such, formal models of practice distort the very practice that they purport to describe.
The central notion of Bourdieu's theory of practice is the relational and dynamic nature of the interaction between habitus and field (and the distribution and acquisition of capital) that gives shape to the social world. In essence, Bourdieu's theory describes that social structures (field) and mental structures (habitus) are inevitably linked to each other, and that the dispositions of the habitus are embodied representations of the social structures existing in the field. In this manner, Bourdieu (1990) asserts that the habitus and field are 'ontologically complicit' with each other. The structures of the social field form the habitus, which in turn, serves to perpetuate the structures of the social field. Once again, however, it is necessary to note that Bourdieu does not conceive of this relationship as deterministic. Over time, and with new exposures, the generative nature of habitus allows practice to change and evolve, which then serves to change the nature of the field, but that this evolution is slow. Largely, the habitus serves to perpetuate the structures within which it was formed.

Each encounter between an individual and a field is conceived as being a mediation, between the habitus and the field, in Bourdieu's terms “between objective structures and practices”. Bourdieu describes the habitus as providing the individual with practical sense, and frequently uses the analogy of the player who develops ‘a feel for the game’, which is not attributable to either just a knowledge of pre-existent structures or rules or to the rote performance of repetitive or rule-bound actions. A lengthy quote from Bourdieu (1990) gives elegant description to this process as he describes:
... the almost miraculous encounter between the *habitus* and a field, between incorporated history and an objectified history, which make possible the near-perfect anticipation of the future inscribed in all the concrete configurations on the pitch or board. Produced by experience of the game, and therefore of the objective structures within which it is played out, the ‘feel for the game’ is what gives the game a subjective sense—a meaning and a *raison d’être*, but also a direction, an orientation, an impending outcome, for those who take part and therefore acknowledge what is at stake (this is *illusio* in the sense of investment in the game and the outcome, interest in the game, commitment to the presuppositions—*doxa*—of the game). And it also gives the game an objective sense, because the sense of the probable outcome that is given by practical mastery of the specific regularities that constitute the economy of a field is the basis of ‘sensible’ practices, linked intelligibly to the conditions of their enactment, and also among themselves, and therefore immediately filled with sense and rationality for every individual who has the feel for the game [emphasis added]. (p. 66).

Hence, to Bourdieu, a field is a structured system of social relations among individuals, groups, and institutions, in which an individual locates oneself for practice and also assumes a specific space within the system of relations. Therefore, practice is an *orchestration* an individual makes in a setting of on-going actions between the habitus and the specific character of the field. The
sociocultural context of practice, conceptualized as field has three intertwined impacts on practice: (a) as the locus within which the habitus of practice is generated, molded, evolving and learned by the ‘inhabitants’, (b) as the field of practice that is characterized by specific structural forms, which orient individuals for on-the-spot orchestration of actions, and (c) as the social arena in which an individual occupies a specific space of relations.

Using this perspective then, knowledge of both the structures and relationships within a field is key to understanding the practices of agents within the field. A field is both the location within which practice occurs and the setting in which agents are positioned, and in which they may attempt to alter their position by acquiring or converting capital or preserving their position through maintaining the status quo.

Bourdieu’s theory of practice provides a potential lens through which to examine nurses’ pain assessment practice. It is possible to conceptualize nursing pain assessment as a form of human practice. Accordingly, each nurse brings to each encounter with a postoperative client, a ‘nursing pain assessment habitus’ which is the product of the nurse’s experience. Experiences in this field (or others) have shaped the nurse’s dispositions to conduct assessments in a particular way. Similarly, there are unique demands and rules that are embedded in the field itself, as well as a collective nursing pain assessment habitus which is characteristic of nurses practicing in this field. The proposed study will attempt to provide a
description of nursing pain assessment as it is practiced in two selected nursing units.
CHAPTER FOUR

METHODOLOGY

In keeping with the framework developed by Bourdieu and the methodology used in Bourdieu's work, the study used a theory-based ethnographic design (Bourdieu, 1984, 1990; Bourdieu & Wacquant, 1992; Pelto & Pelto, 1978). Pain assessment, as a practice behavior, occurs within specific clinical fields and is heavily influenced by the habitus of the individual and the predominant habitus present within the field. It was therefore appropriate to study pain assessment within the context of the theory of practice, and to do so using Bourdieu's suggested method. This approach provides an alternative lens from which to understand the forces with shape nurses' pain assessment practice, and to build on the findings of previous studies which have suggested that variables within the nursing unit impact on the pain assessment practice of the individual nurse. Each nursing unit is conceptualized as a field, with its own set of structured relationships and its own forms of capital. As well, nursing units are also contained within larger "nursing fields" and "organizational fields". It is proposed that each nurse brings a 'nursing habitus' and more specifically, a 'pain assessment habitus' to each encounter with a postoperative client. This habitus is the product of the nurses' experience and the historical experience embedded in the field. However, because the dispositions of the habitus are formed in practice, it is proposed that nurses practicing in the same field will demonstrate similar dispositions of the habitus. In essence, according to Bourdieu's theory, one would
expect to encounter a predominant nursing pain assessment habitus in each field, and would also expect that the pain assessment habitus will be different between the two fields.

**Research Questions**

In keeping with the general aims described, the study was guided by the following four research questions:

1. What is the nature of the sociocultural field of nursing pain assessment practice in each of two postoperative units?

2. What specific assessment strategies do nurses use in each of these two fields (individual dispositions of the habitus)?

3. What is the predominant nursing pain assessment habitus in each of the two fields?

4. What are the differences in nursing pain assessment habitus between the two fields?

**Overall Design**

The dissertation consisted of two related studies. The overarching design for the study was a four phase ethnography using multiple data collection methods. This study was carried out in two distinct surgical nursing units within the same organization. However, before the principal study could be conducted, it was necessary to develop a quantitative instrument to be used in the third phase of the ethnography. This instrument was designed to assess the specific strategies that
nurses use to assess pain in postoperative clients. Instrument development constitutes the preliminary study conducted as part of the dissertation.

**Preliminary Study: Instrument Development**

Key to answering the third research question was the ability to measure nurses’ pain assessment strategies in each of the two units studied. To date, the only published instrument to measure the character of nurses’ pain assessment is the Pain Assessment Questionnaire (Dalton, 1989; Dalton et al., 1998), however this instrument is specific to the assessment of clients with cancer, and is not wholly appropriate to the strategies nurses might use to assess postoperative clients. For the purposes of this study, the modalities of assessment identified by Sjöström and colleagues (Sjostrom, 1999; Sjostrom, Dahlgren & Haljamae, 1999; Sjostrom, Dahlgren & Haljamae, 2000) formed the basis for the development of an instrument to measure nursing assessment habitus. Development of this instrument comprised a preliminary phase to the principal study. The strategies identified in Sjöström work have been confirmed in a number of cross-national studies, and in each instance have been exhaustive of the strategies used by nurses to assess pain in postoperative settings. The instrument was developed in collaboration with Dr. Sjöström, who serves as a cosponsor to the larger study, and Dr. Hesook Suzie Kim and Dr. Donna Schwartz-Barcott who have served as co-investigators with Dr. Sjöström on the pain assessment studies.
The instrument was developed using a standard approach to instrument development (see, for example Gable [1986]; Waltz, Strickland, & Lenz, [1991]), and was conducted using the following thirteen steps outlined by Gable (1986).

1. **Develop Conceptual Definition**

   For this study, the conceptual definition of habitus used will be that provided by Bourdieu (1990b). Habitus is defined as:

   systems of durable, transposable, *dispositions*, structured structures

   predisposed to function as structuring structures, that is, as principles of the generation and structuring of practices and representations which can be objectively ‘regulated’ and ‘regular’ without in any way being the product of obedience to rules, objectively adapted to their goals without presupposing a conscious aiming at ends or an express mastery of the operation necessary to attain them and, being all this, collectively orchestrated without being the product of the orchestrating action of a conductor. (Bourdieu, 1977, p. 72)

2. **Develop Operational Definition**

   Operational definitions for nursing pain assessment habitus were drawn from the specific assessment strategies arising from the work of Sjöström and colleagues. These studies suggest four broad categories of strategies that nurse’s use when assessing postoperative pain in clients. These include: how the client looks, what the client says, the client’s way of talking, and experience of similar circumstances. These four broad categories of assessment strategies, which have
been validated in subsequent studies in the US, Sweden and Korea, formed the
four dimensions of nursing assessment for subsequent item development.

3. **Select a Scaling Technique**

The instrument consists of a Likert scale, whereby nurses rate their use of
specific criteria for assessment of pain in postoperative clients from 1 “don’t use
it” to 5 “use it all the time”.

4. **Item Development/Judgmental Review of Items**

The scale consists of twenty items, in five dimensions:

1. How the clients looks
2. What the client says
3. The client’s way of talking
4. Experience of similar circumstances
5. Distracters unrelated to pain assessment

The items address specific strategies that nurses use to assess pain in
postoperative clients. For example, items in the “how the client looks” dimension
include, “I observe the client’s facial expression” or “I observe the client’s ability
to turn and cough”.

Content validity (the degree to which items on the instrument adequately
sample from the intended universe of content (Gable, 1986) was assessed by a
panel of experts (including Dr. Sjöström, Dr. Hesook Suzie Kim and Dr. Donna
Schwartz-Barcott who have served on co-investigators on cross-national studies of
nurses’ pain assessment). Additionally, the data collected during phase II of the
ethnography will provided an inventory of the strategies that nurses used in their assessments of postoperative clients. These data were compared to items presented on the scale and to the criteria described by Sjostrom.

5. **Select a Response Format**

   The response format was a 5 point Likert scale, which allowed nurses to indicate the frequency with which they use a particular assessment strategy, ranging from never to always

6. **Develop directions for Responding**

   Directions for responding to the instrument were developed in consultation with Drs. Kim, Sjostrom and Schwartz-Barcott.

7. **Prepare a draft of the Instrument and Gather Preliminary Pilot Data**

   A tentative layout of the draft instrument was developed, and reviewed by colleagues for clarity, readability and ease of responding. The draft instrument was then administered to a sample of five nurses known to the researcher. The nurses were asked to assess the instrument for clarity, readability, ease of responding. No revisions were made on the basis of this assessment.

   Therefore, the final version of the instrument consisted of 20 items, along five dimensions. Four items are presented for each dimension in the instrument. Each item is rated on a five point Likert scale from 1 “don’t use it” to 5 “always use it”.

8. **Prepare the Final Instrument**

   The final instrument was prepared and printed.
9. Gather Final Pilot Data

Following appropriate IRB review and approval, the instrument was administered to a convenience sample of 320 Registered Nurses working on fifteen surgical nursing units at three hospitals in Rhode Island. Nurse managers on each of the units were responsible for distribution of the instrument to each Registered Nurse working on the specific unit. Questionnaires were distributed, along with written description of the purpose of the study, and explanations of procedures to ensure anonymity of responses. A sealed box was provided on each unit for the nurse to return completed questionnaires. Approximately two weeks after initial distribution, reminder posters were placed on each of the units, and second copies of the instruments were made available to nurses who had not responded to the first request for participation.

The Principal Study: Ethnography

Setting

The setting for this study was two general surgical units in a large teaching hospital in the Northeastern United States. The units provide care to the same general surgery client population and were chosen for a number of reasons. First, because the purpose of the study was to explore the difference in nursing pain assessment habitus, it was important to choose two units where one would expect to see differences. Past experience with data collection for a previous study by another research team has suggested that each of these units possesses a unique culture, with a distinct approach to client care. Secondly, the units are located
within the same organization. Because they operate under the same organizational structure, philosophy and mission, differences in approach are more likely to be attributable to unit specific factors than to broader organizational issues. Because both units provide care to postoperative client undergoing general surgery, differences in pain assessment habitus, if they exist, are more likely to be attributable to unit specific culture than to differences in client populations and client needs. Finally, both units have relatively stable levels of staffing, with nurses with relatively long tenure in the specific unit. Therefore, it was anticipated that the nurses would display a pain assessment habitus that has been formed in the setting in which they are currently practicing.

**Research Design**

The method chosen for this study is consistent with Bourdieu’s theory of practice. The central concept in Bourdieu’s research methodology is ‘reflexivity’. The researcher conducting research is also a practitioner in practice, and therefore it is necessary for the researcher to make an ‘epistemological break’ from his or her own practice in such a way that allows him or her to objectify the relationship between the researcher and the objects of study (Grenfell & James, 1998). In keeping with Bourdieu's framework, the traditional ethnographic approach (Bernard, 1998; Pelto & Pelto, 1978), and Bourdieu's own approach to method (1977, 1984, 1990), this study employed multiple data collection techniques, including participant observation, individual interviews, small focus groups and
the use of a quantitative survey tool. The study was conducted in four phases, over a period of seven months.

Phase 1

Following institutional IRB approval, this phase focused primarily on the first research question, and was carried out simultaneously in two fields. The goal of this phase was to provide a description of the structural relations within each of the fields as they relate to nursing pain assessment, including identification of relevant actors within the field, their positions in terms of power, influence, and an identification of the forms of capital exchanged within the field. Analysis of the field followed the three steps described by Bourdieu and Wacquant (1992):

1. Analyze the positions of the field vis-à-vis the field of power,
2. Map out the objective structure of relations between the positions occupied by agents (in this case nurses, clients, families, physicians, etc.),
3. Analyze the habitus of the agents (in this instance specific pain assessment strategies used by nurses represent the dispositions of the nursing pain assessment habitus).

The principle method for data collection in this phase was participant observation. The researcher was present on the units, observing nurses in their care of postoperative clients, specifically the assessment of pain in these clients. Primary data were recorded through the use of extensive field notes. A small spiral bound notebook served to provide the least obtrusive method to record preliminary field notes while in the setting.
These notes consisted of key phrases, observations and ideas, described by Bernard (2002) as "field jottings". At the end of each day of data collection, these notes then provided an outline for more complete notes, which were dictated into a voice recorder and then transcribed, and became the basis for the development of complete observational, methodological and analytic notes.

The strategy for organizing and analyzing field notes was guided by the research questions and informed by the techniques presented in Bernard (1998). In keeping with both classical ethnographic practice, and Bourdieu's technique, field notes were coded and analyzed on an ongoing basis.

In the first weeks of data collection, the major focus was on mapping out the relative positions of various actors within each of the fields, and in situating the researcher within the field. At this stage, there was also a focus on identifying the prevailing forms of capital in each field and assessing the distribution of capital amongst various actors in each field.

It is important to note that while there are many significant actors other than nurses in each field (notably clients and physicians), the purpose of this ethnography is to assess nursing assessment habitus, and therefore the predominant focus of data collection was on nurses themselves. This type of delimitation of actors in a specific position within the field is consistent with Bourdieu's approach in identifying professorial habitus in Homo Academicus (Bourdieu, 1984b), and in the identification of the habitus of taste in various subcultures in France in Distinction (Bourdieu, 1984a), and Cassel's description of
the interpersonal habitus of female surgeons (Cassel, 1998). Data collection focused most intently on the nurses themselves, and other actors were of interest only to the extent to which they influence the nurses' pain assessment practices. Quantitative data to describe the fields were also collected. Phase 1 data collection was also continued throughout the duration of the study.

Phase II

The goal of phase two was to provide specific description of individual nursing pain assessment habitus in each field. The data collection strategies for this phase included participant observation and individual interviews. This phase focused intensely on a small sample of nurses in each field. Because data collection was limited to the day shift (7:00-3:00), only those nurses working the day shift were eligible for participation. On unit A, ten of the twelve nurses (83.3%) working the day shift agreed to participate in the study. These nurses represented varying degrees of experience in this unit, ranging from six (6) months to twenty six (26) years. On Unit B, ten (10) of the thirteen (13) RNs (76.9%) working day shift agreed to participate. These nurses had between two (2) weeks and seventeen (17) years of experience on Unit B.

When the nurse was caring for clients who were able to provide consent, the nurse was observed carrying out pain assessments, and data was recorded using the same field note strategy as in Phase One. If the nurse was caring for clients who were unable to provide consent, then no observations were conducted, and data were obtained through interview alone. Preliminary analysis of the data was
conducted following each recording to identify specific dispositions of the habitus (specific behaviors).

The predominant data collection method in this phase was the use of semi-structured interviews with the nurses conducted as close as possible in time following conduct of assessment. Interviews were conducted on the nursing unit, during the nurse’s regularly scheduled work shift. Interview questions and probes were designed to elicit nurse’s understanding of the strategies they used in assessment of specific clients and how these skills were developed, and were based on relationships identified in previous work (i.e. “What kinds of things did you consider in assessing Mr. X.?”, “What has your experience taught you about assessing clients like Mr. X.?”). These types of questions have been successfully used by Sjöström and colleagues to gain access to nurses’ pain assessment strategies.

While it was initially anticipated that each interview would last between 60 and 75 minutes, this proved to be impractical for nurses on busy surgical units. The interviews lasted between 13 and 54 minutes, with the majority lasting 20-25 minutes. The interviews were audiotaped and transcribed verbatim. One of the first interviews on Unit B was lost due to a recorder malfunction, and was unable to be recreated, leaving a total of nine interviews from Unit B available for analysis. After this incident, in addition to voice recordings, brief notes were recorded during each interview.
Again the data management strategies outlined by Pelto & Pelto (1978) were used. Notes and interview transcripts were initially coded for the four criteria identified by Sjostrom and colleagues, and then recoded and analyzed as patterns began to appear. Periodically, the notes were shared with the two members of the dissertation committee, to both strengthen and confirm data analysis. Findings from each episode of analysis was be used to guide data collection in subsequent interviews.

Phase III

The third phase of the study focused largely on the identification and description of the predominant nursing pain assessment habitus in each field. This phase was also informed by the interview data collected in Phase II. The two data collection strategies used in this phase included focus group interviews and the use of a quantitative survey instrument. On each of the two units, a single focus group discussion was held in order to provide another level of understanding of the nature of relationships within the field, and how these relationships shape nurses' pain assessment strategies. The sessions lasted from 35 to 45 minutes, and were audiotaped and transcribed verbatim. Along with data obtained in phase two, these interviews were used to provide a description of the predominant nursing pain assessment habitus in each field.

The Pain Assessment Inventory was also used to provide data regarding the predominant nursing pain assessment habitus in each field, and to examine differences between the two fields. Variables of interest included: the practice
setting (unit); quantity of nursing experience, years of experience in the particular unit (tenure), and specific strategies used in the assessment of pain. Data obtained through quantitative methods were analyzed to illustrate:

a) any differences in the characteristics of the units;
b) any differences between the two units in terms of the representative modes of pain assessment strategies used by the nurses on each unit; and
c) the differences in the modes of pain assessment strategies used by the nurses in terms of the nurses' experience and their tenure on each of the units.

Nurses who participated in Phase II of the study completed the survey instrument twice, once following an initial assessment of a client, and later, following their interview. This data was used to assess stability of the instrument over time (test-retest).

Additional analyses were performed to examine the relationships among nurses' unit affiliation, their tenure, their attitudes regarding pain assessment and the strategies used in pain assessment.

Unlike the earlier analysis, which focused on in-depth participant observation of a limited number of nurses in each setting, the sample for the quantitative analysis included all Registered Nurses regularly employed as staff nurses on each of the units under study. At the time of the study, 27 RN's were employed on Unit A, and 30 RN's on Unit B.
As described earlier, nurses who participated in Phase II data collection completed the Pain Assessment Inventory during the observation process. The Pain Assessment Inventory was distributed to the remainder of the RN's on each unit in a sealed envelope, and nurse who chose to participate returned the inventory to a sealed box placed on each of the units.

For individual nurses, practice setting, years of nursing experience and years of experience in the particular unit were be assessed by single item demographic measures. In addition, because immersion in the sociocultural field is a key variable, the nature of the nurses' employment status on the unit (i.e. regular full time, part time, per diem, traveler) was assessed.

The instrument was used to conduct three sets of approaches to analysis. Initially, the data were analyzed to examine patterns of pain assessment strategies distinct in each of the units. Profile analysis techniques were used to determine whether there are emerging prototypical modes of pain assessment distinguishing each of the units. Secondly, an analysis of differences in nurses' attitudes and strategies regarding pain assessment was made in terms of their nursing experience and tenure in a particular unit, applying discriminant function analysis. Thirdly, the data were examined for differences between the two units in terms of the attitudes regarding and strategies used in pain assessment, applying non-parametric tests, including the cross classification procedure using Chi squared tests. These analyses were used to illuminate, support or contrast the findings from the qualitative data analysis. Thus, the quantitative data served to confirm
(or refute) the more descriptive data provided through observation, interview and focus groups.

Phase IV

In keeping with traditional approaches to ethnography, the final phase was conducted outside of the fields of study, and consisted of final analysis of data from all phases and preparation of the final product. The goal of this phase was to draw together the data pertaining to the four research questions in order to provide a descriptive model of nursing pain assessment practice in two distinct nursing units.

Credibility in Fieldwork

A number of different approaches to the assessment of credibility in fieldwork, have been posited. This study was guided by the criteria described by Davies (1999). Unlike others, who have argued that the criteria of reliability, validity and generalizability are not applicable to the analysis and evaluation of credibility of ethnographic research, Davies argues that these criteria are essential to the evaluation of this type of work, but that the ways in which we assess them are unique when considering ethnography.

For Davies, the validity of findings is enhanced when a variety of methods are used for data collection. This study, like most ethnographic work, relied on multiple means of data collection including participant observation, individual interviews, focus groups and a quantitative survey. The use of multiple methods to
address each research question serves to strengthen the validity of the study findings.

Davies also suggests that there are unique expectations for reliability that apply to the conduct of ethnographic research. From this perspective, it is not realistic, or even desirable, to expect that a replication would lead to the same results. For Davies, the reflexive nature of ethnography makes it such that, even the same researcher "is a different person on subsequent field trips to the same research site" (Davies, 1999, p. 90). Therefore, the strictest interpretation of reliability used in quantitative research is inapplicable to ethnographic work. However, Davies suggests that ethnographic researchers are concerned with reliability in the context of their own work in terms of "continually crosschecking information they obtain and interpretations they develop" (Davies, 1999, p. 90). In this study, reflexive ethnography dictated that the researcher regularly returns to the data to verify and corroborate findings. Also, because the dissertation committee members had access to the raw data, and the perspectives of multiple researchers served to enhance the reliability of conclusions. For this researcher, there was also a concern that the data obtained through participant observation be a full and accurate representation of nursing pain assessment in the two fields. While members of the dissertation committee were able to confirm the coding and analysis of the data, they were unable to confirm that the observational notes recorded in Phase I reflected pain assessment practice as it existed in the two fields. For this measure of reliability, a key informant in the organization, who has
in depth knowledge of nurses’ pain assessment practice on both units served as an informal sounding board through the early phases of data collection. Through a series of informal meetings, the researcher was able to develop confidence that the data collected was truly reflective of nursing pain assessment on each unit.

The final criterion is generalizability. Davies argues that there are two forms of generalization that are used in ethnographic research. First, empirical generalization “means that the findings of a study are extended to other cases, judged to be similar, but which were not included in the fieldwork of the original study” (Davies, 1999, p. 91). This form of generalization poses difficulty in that it is necessary to specify appropriate boundaries within which generalization may be appropriate. Davies suggests that a more appropriate form of generalization for ethnographic work is theoretical inference. In this sense, “the conclusions of ethnographic analysis are seen to be generalizable in the context of a particular theoretical debate rather than being primarily concerned to extend them to a larger collectivity” (Davies, 1999, p. 91). This form of generalizability was central to the conduct of this study. The purpose of the study was to apply Bourdieu’s theory of practice to the study of one particular nursing practice activity (pain assessment) in two settings, in order to assess the applicability of the theory in assessing and understanding nursing practice. The aim of the study was to develop a descriptive model of how this process occurs in these two settings.
Ethical Considerations

Ethical issues are addressed for both the preliminary study, and the principal study.

The Preliminary Study

The sample for the preliminary study consisted of a convenience sample of 320 Registered Nurses working in three hospitals in Rhode Island. Following institutional IRB approval, the purpose of the study was explained to nurses by nurse managers within each of the organizations. An introductory letter describing the purpose of the study was provided to each nurse working on the participating units. Participation in the study consisted of filling out a 20 item survey tool. The time required to complete the instrument was approximately 15 minutes. Completed questionnaires were returned to sealed boxes provided on each of the units. Participation in the study was anonymous, and no risks or benefits are anticipated for nurses as a result of participation in the study. Return of the completed questionnaires was considered as implied consent to participate.

The Principal Study

Human subjects involved in the study were those Registered Nurses employed on each of the two units under study who consented to participate in the study.

Criteria for inclusion were all Registered Nurses working on each of the two units under study who agree to participate in the study. Following IRB approval, the purpose of the study and data collection methods were presented to
the nurses by the researcher at regularly scheduled unit meetings. The researcher made specific efforts to ensure that the sample was mixed both ethnically and according to gender by making personal appeals to nurses from diverse backgrounds to consider participation in the study.

Those nurses who chose to participate in interviews were asked to sign a written consent form which detailed the specific elements of data collection. Nurses who consented to participate in this portion of the study consented to:

1. Be accompanied by the researcher during their assessment of postoperative client's pain.

2. Participate in a semi-structured interview with the researcher following each assessment to discuss the specific strategies they used in their assessment, where they learned the strategies they use, what they have learned about assessment through experience.

3. Complete the Pain Assessment Inventory twice; once following their assessment of a postoperative client, and once at the conclusion of their interview.

Nurses also consented to participate in small focus groups with other nurses to discuss pain assessment strategies on the unit.

The nurses' participation was completely voluntary and nurses were informed that they may choose to withdraw from the study at any time. No nurse who provided consent later elected to withdraw from the study. Data collected through field notes was coded by number only. Field notes and interview
transcripts were shared only with the dissertation committee, and nurses were identified pseudonyms. Individual nurses were not identified.

Any presentation of the data, including this dissertation report and any subsequent publications will not provide identifying information. In order to observe nurses conducting pain assessments, it was also necessary to obtain written consent from the clients who were being cared for. If a client was unable to provide informed consent, observation was not carried out.

Because the quantitative portion of the study involved a larger sample, some nurses participated only in the quantitative portion of the study. Again, this option was explained to nurses at regularly scheduled staff meetings. In this instance, a letter of information was provided to each of the nurses, and return of the completed questionnaires was determined to imply consent.

There are no risks or benefits anticipated for nurses who chose to participate in this study. It is possible that nurses may have conducted pain assessments differently due to the researcher’s presence, but strategies were undertaken to minimize this impact. For example, the researcher’s presence on the unit as a participant observer over a long period of time tended to minimize disruption caused by her presence. Secondly, the nurses were informed that the purpose of the study was to learn how nurses on this unit conduct pain assessments, not to evaluate the nurses’ conduct of assessment.
It is anticipated that the knowledge gained from this study will guide the development of new interventions designed to improve client outcomes, by enhancing nurses' assessment of pain.
CHAPTER FIVE

THE PRELIMINARY STUDY: FINDINGS

Sample

The Pain Assessment Inventory was administered to a sample of three hundred twenty (320) Registered Nurses working in fifteen (15) surgical units at three hospitals in Southern New England. Because these data were collected solely for the purpose of analysis and testing of the instrument, no demographic data regarding the sample were collected.

One hundred and ninety three (193) completed surveys were returned, representing a response rate of 60.3%. Response rates across individual units ranged from 46.7 to 100%.

Instrument

The Pain Assessment Inventory (Appendix B) was developed to assess the specific strategies that nurses use to assess pain in postoperative clients. The version of the instrument used for the preliminary study consisted of 20 items representing five subscales or factors, based on the four criteria developed by Sjöström and colleagues (how the patient looks, what the patients says, the patient’s way of talking and experience in similar circumstances) (Sjöström, 1995; Sjöström et al., 1999; Kim & Sjöström, 2000) and a fifth subscale consisting of distracter items not substantively related to pain assessment. Four items were provided for each subscale.
The instrument's introductory statement asks nurses to rate each item on a five-point Likert scale, ranging from 1 (don't use it) to 5 (always use it) with respect to their use of each item when assessing pain in postoperative clients.

An additional item asks nurses to identify one of the listed strategies they would use to assess pain in postoperative clients if they could choose only one.

**Preliminary Analysis**

Descriptive statistics for each of the items on the original instrument are presented in Table 1. While mean scores on many of the items were very high, all items met the criteria for normal distribution.

Cronbach's alpha was calculated for the five proposed factors. Cronbach's alpha ranged from .75 to .85. Table 2 lists each of the five original factors, along with the items included in each factor, and factor alphas for the pilot study sample.

**Factor Analysis**

Next, confirmatory factor analysis was used in an attempt to verify the factor structure of the instrument. Gable describes that the purpose of factor analysis is "to examine empirically, the interrelationships among the items and to identify clusters of items that share sufficient variation to justify their existence as a factor or construct to be measure by the instrument" (p. 85). Gable proposes, "a confirmatory approach is more applicable to instrument development in that the developer examines the derived constructs in light of theoretical predictions that follow from the literature review and operational definitions" (p. 87).
<table>
<thead>
<tr>
<th>Item Number</th>
<th>Keyword</th>
<th>N</th>
<th>Number Missing</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Skewness</th>
<th>Kurtosis</th>
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</thead>
<tbody>
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<td>1</td>
<td>Facial</td>
<td>191</td>
<td>2</td>
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<td>2.000000</td>
<td>5.000000</td>
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<td>1.5821092</td>
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<td>1.0827458</td>
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<td>Talks to others</td>
<td>192</td>
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<td>1.000000</td>
<td>5.000000</td>
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<td>1.3216805</td>
<td>1.000000</td>
<td>5.000000</td>
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<td>11</td>
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<td>5.000000</td>
<td>-1.0226400</td>
<td>0.1887839</td>
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<tr>
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<td>Temperature</td>
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<td>5.000000</td>
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<td>-0.9911216</td>
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<td>1.000000</td>
<td>5.000000</td>
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<td>-0.3318530</td>
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<td>Words</td>
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<td>4.3782383</td>
<td>0.7951304</td>
<td>2.000000</td>
<td>5.000000</td>
<td>-1.1640041</td>
<td>0.7311520</td>
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<td>15</td>
<td>Surgery</td>
<td>192</td>
<td>1</td>
<td>3.0833333</td>
<td>1.1501574</td>
<td>1.000000</td>
<td>5.000000</td>
<td>0.0442390</td>
<td>-0.9013343</td>
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<td>Talks</td>
<td>191</td>
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<td>4.0261780</td>
<td>0.8425185</td>
<td>2.000000</td>
<td>5.000000</td>
<td>-0.3699332</td>
<td>-0.7753934</td>
</tr>
<tr>
<td>17</td>
<td>Body</td>
<td>191</td>
<td>2</td>
<td>4.260157</td>
<td>0.6935120</td>
<td>2.000000</td>
<td>5.000000</td>
<td>-0.5076875</td>
<td>-0.4427603</td>
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<tr>
<td>18</td>
<td>Similar</td>
<td>192</td>
<td>1</td>
<td>3.1041667</td>
<td>1.1254241</td>
<td>1.000000</td>
<td>5.000000</td>
<td>-0.0512799</td>
<td>-0.6835674</td>
</tr>
<tr>
<td>19</td>
<td>Overall</td>
<td>192</td>
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<td>4.2708333</td>
<td>0.7857256</td>
<td>2.000000</td>
<td>5.000000</td>
<td>-0.7811693</td>
<td>-0.1466076</td>
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<tr>
<td>20</td>
<td>Turgor</td>
<td>192</td>
<td>1</td>
<td>2.5520833</td>
<td>1.2479914</td>
<td>1.000000</td>
<td>5.000000</td>
<td>0.5579764</td>
<td>-0.6658003</td>
</tr>
</tbody>
</table>

Table 1

Descriptive Statistics for the Pain Assessment Inventory
Table 2

*Cronbach’s Alpha Values for the Original Factors of the Pain Assessment Inventory*

<table>
<thead>
<tr>
<th>Factor</th>
<th>Items</th>
<th>Alpha</th>
</tr>
</thead>
</table>
| How the patient looks           | 1. I observe the patient’s facial expression.  
2. I observe how the patient moves.  
3. I observe the patient’s body posture/position.  
4. I observe the patient’s overall demeanor. | .7745  |
|                                  | (n=188)                                                                                                                                 |        |
| What the patient says           | 2. I listen to the patient’s description of his or her pain.  
3. I listen to the patient’s rating of his or her pain.  
4. I listen to what the patient says about his or her pain.  
5. I listen to specific words the patient uses to describe his or her pain. | .8263  |
|                                  | (n=193)                                                                                                                                 |        |
| The patient’s way of talking    | 6. I observe the way the patient walks with others.  
7. I look for moaning or grunting.  
8. I listen to the patient’s tone of voice.  
9. I listen to the way the patient talks. | .7516  |
|                                  | (n=190)                                                                                                                                 |        |
| Experience in similar circumstances | 4. I know what to expect from patients who have had different kinds of surgery.  
5. I think about past experiences related to pain management.  
6. I have learned what patients who have this surgery generally experience.  
7. I think about past experiences and patients in similar circumstances. | .8542  |
|                                  | (n=190)                                                                                                                                 |        |
| Distractors                      | 6. I ask about support available from the patient’s family.  
7. I review the patient’s intake and output.  
8. I assess the patient’s temperature.  
9. I assess the patient’s skin turgor. | .8406  |
|                                  | (n=187)                                                                                                                                 |        |

Confirmatory analysis using the original five factor structure of the instrument indicated poor fit for the original five factor structure as hypothesized (GFI=.9129, Chi-square 45.08, df=5, p<.0001, RMSEA = 0.2043, CFI = 0.8962, NNFI = 0.8863). Because the confirmatory factor analysis failed to support the hypothesized factor structure of the instrument, an exploratory factor analysis was conducted in an attempt to explore the underlying factor structure of the instrument. Using an orthogonal rotation, this procedure suggested a four-factor structure. The rotated factor pattern is presented in Table 3.
Following examination of the factor loadings as presented in Table 3, two solutions were again tested using confirmatory factor analysis. The first was a three factor solution which consisted of:

1. All client-related items (items 1, 2, 3, 5, 8, 10, 11, 13, 14, 16, 17 and 19),
2. All experience-related items [items 4, 7, 15 and 18] and,
3. Distracters [items 6, 9, 12 and 20].

The three factor solution yielded a good fit model (GFI = 1.000, chi-square = 0.000, df = 0, p < 0.0001, RMSEA = 0.000, CFI = 1.000, NNFI = 1.000). While

Table 3

<table>
<thead>
<tr>
<th>Item No.</th>
<th>Key Word</th>
<th>Factor 1</th>
<th>Factor 2</th>
<th>Factor 3</th>
<th>Factor 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Says</td>
<td>.85229</td>
<td>.18750</td>
<td>.01630</td>
<td>.04268</td>
</tr>
<tr>
<td>14</td>
<td>Words</td>
<td>.81074</td>
<td>.02215</td>
<td>.18183</td>
<td>-.00714</td>
</tr>
<tr>
<td>5</td>
<td>Rating</td>
<td>.77236</td>
<td>-.07493</td>
<td>.08376</td>
<td>.07943</td>
</tr>
<tr>
<td>2</td>
<td>Description</td>
<td>.75514</td>
<td>.25393</td>
<td>-.00328</td>
<td>.09255</td>
</tr>
<tr>
<td>3</td>
<td>Moves</td>
<td>.62763</td>
<td>.40813</td>
<td>.10594</td>
<td>.07109</td>
</tr>
<tr>
<td>17</td>
<td>Body</td>
<td>.56083</td>
<td>.51951</td>
<td>.21917</td>
<td>.16788</td>
</tr>
<tr>
<td>1</td>
<td>Facial</td>
<td>.03759</td>
<td>.85681</td>
<td>.05978</td>
<td>.11734</td>
</tr>
<tr>
<td>11</td>
<td>Moan</td>
<td>-.01449</td>
<td>.79138</td>
<td>.07949</td>
<td>.28191</td>
</tr>
<tr>
<td>13</td>
<td>Voice</td>
<td>.26923</td>
<td>.66783</td>
<td>.22447</td>
<td>.18069</td>
</tr>
<tr>
<td>16</td>
<td>Talks</td>
<td>.37354</td>
<td>.60220</td>
<td>.19155</td>
<td>.25562</td>
</tr>
<tr>
<td>19</td>
<td>Overall</td>
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<td>.55448</td>
<td>.14141</td>
<td>.27528</td>
</tr>
<tr>
<td>8</td>
<td>Talks to others</td>
<td>.27611</td>
<td>.45710</td>
<td>.43766</td>
<td>-.04200</td>
</tr>
<tr>
<td>20</td>
<td>Turgor</td>
<td>-.09918</td>
<td>.22002</td>
<td>.80331</td>
<td>.24607</td>
</tr>
<tr>
<td>12</td>
<td>Temperature</td>
<td>.12717</td>
<td>.10090</td>
<td>.76787</td>
<td>.23435</td>
</tr>
<tr>
<td>6</td>
<td>Support</td>
<td>.16115</td>
<td>-.03634</td>
<td>.71916</td>
<td>.16252</td>
</tr>
<tr>
<td>9</td>
<td>Intake</td>
<td>.12555</td>
<td>.35651</td>
<td>.70728</td>
<td>.29164</td>
</tr>
<tr>
<td>15</td>
<td>Surgery</td>
<td>-.00814</td>
<td>.23300</td>
<td>.22162</td>
<td>.84171</td>
</tr>
<tr>
<td>4</td>
<td>Expect</td>
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<td>.12577</td>
<td>.15792</td>
<td>.83623</td>
</tr>
<tr>
<td>18</td>
<td>Similar</td>
<td>.10887</td>
<td>.20929</td>
<td>.27745</td>
<td>.78712</td>
</tr>
</tbody>
</table>

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this model represents the best statistical fit, it fails to acknowledge the distinction
between information the nurse receives directly from the clients, and information
the nurse receives through observation of the client. Theoretically, this distinction
is proposed to be important in practice.

Therefore, a four factor solution was proposed, using the items outlined in
boldface type in Table 3. This solution is theoretically appropriate, and results in
an instrument that addresses three key modes of assessment. The items included
under the original categories of “the patient’s way of talking” and “the way the
patient looks” were collapsed into one factor representing criteria that the nurse
observes in the client. Items that loaded heavily on more than one factor were
eliminated, and four factors were retained. These factors are:

1. The client’s description of their pain:
   - I listen to the patient’s description of his or her pain
   - I listen to the patient’s rating of his or her pain
   - I listen to what the patient says about his or her pain
   - I listen to specific words the patient uses to describe his or her pain

2. Criteria the nurse observes in the client:
   - I observe the patient’s facial expression
   - I look for moaning or grunting
   - I listen to the patient’s tone of voice

3. What the nurse has learned from previous experience:
• I know what to expect from patients who have had different kinds of surgery
• I think about past experiences related to pain management
• I have learned what patients who have this surgery generally experience
• I think about past experiences, and patients in similar circumstances

4. Distracters (items not related to pain assessment)
• I ask about support available from the patient’s family
• I review the patient’s intake and output
• I assess the patient’s temperature
• I assess the patient’s skin turgor.

This model was subjected to confirmatory factor analysis using SAS PROC CALIS and yielded also yielded a good fit model (GFI = .9929, chi-square = 2.7420, df = 2, p = 0.2539, RMSEA = .0440, CFI .9950, NNFI = .9821).

Finally, reliability (internal consistency) of the new subscales was assessed using Cronbach’s alpha. Alpha for the newly created subscales ranged from .79 to .85. Alpha values for the new subscales are presented in Table 4.

Summary

The preliminary study resulted in the development of the Pain Assessment Inventory, an instrument designed to assess the specific criteria that nurses use when assessing pain in postoperative clients. This instrument measures nurses’ use of criteria from three spheres including: the client’s description of their pain
Table 4

*Cronbach’s Alpha for Final Subscales of the Pain Assessment Inventory*

<table>
<thead>
<tr>
<th>Factor</th>
<th>Items</th>
<th>Alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client’s Narrative</td>
<td>2. I listen to the patient’s description of his or her pain.</td>
<td>0.8263</td>
</tr>
<tr>
<td></td>
<td>5. I listen to the patient’s rating of his or her pain.</td>
<td>0.8263</td>
</tr>
<tr>
<td></td>
<td>10. I listen to what the patient says about his or her pain.</td>
<td>0.8263</td>
</tr>
<tr>
<td></td>
<td>14. I listen to specific words the patient uses to describe his or her pain.</td>
<td>0.8263</td>
</tr>
<tr>
<td></td>
<td>(n=193)</td>
<td></td>
</tr>
<tr>
<td>Evident Criteria</td>
<td>1. I observe the patient’s facial expression.</td>
<td>0.7896</td>
</tr>
<tr>
<td></td>
<td>11. I look for moaning or grunting.</td>
<td>0.7896</td>
</tr>
<tr>
<td></td>
<td>13. I listen to the patient’s tone of voice.</td>
<td>0.7896</td>
</tr>
<tr>
<td></td>
<td>(n=189)</td>
<td></td>
</tr>
<tr>
<td>Reference Typology</td>
<td>4. I know what to expect from patients who have had different kinds of surgery.</td>
<td>0.8542</td>
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<tr>
<td></td>
<td>7. I think about past experiences related to pain management.</td>
<td>0.8542</td>
</tr>
<tr>
<td></td>
<td>15. I have learned what patients who have this surgery generally experience.</td>
<td>0.8542</td>
</tr>
<tr>
<td></td>
<td>18. I think about past experiences and patients in similar circumstances.</td>
<td>0.8542</td>
</tr>
<tr>
<td></td>
<td>(n=190)</td>
<td></td>
</tr>
<tr>
<td>Distracters</td>
<td>6. I ask about support available from the patient’s family.</td>
<td>0.8406</td>
</tr>
<tr>
<td></td>
<td>9. I review the patient’s intake and output.</td>
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<tr>
<td></td>
<td>12. I assess the patient’s temperature.</td>
<td>0.8406</td>
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<tr>
<td></td>
<td>19. I assess the patient’s skin turgor.</td>
<td>0.8406</td>
</tr>
<tr>
<td></td>
<td>(n=187)</td>
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</tbody>
</table>

(Client’s Narrative), criteria the nurse observes in the client (Evident Criteria), and the nurse’s expectation based on his or her experience with clients in similar circumstances (Reference Typology).
CHAPTER SIX

THE ETHNOGRAPHY: FINDINGS

For the ethnographic phase of the study, data collection and analysis were conducted in distinct phases, designed to address specific research questions: the nature of sociocultural field of nursing pain assessment practice in each unit; the specific assessment strategies used in each field; identification of the predominant nursing pain assessment habitus in each field; and differences in nursing pain assessment habitus between the two fields. Findings will be presented for each question, although the second and third research questions, dealing with individual and collective nursing pain assessment habitus will be addressed together.

The Fields

The first research question addressed the nature of the sociocultural field of nursing pain assessment practice in each of two units. Data for this question were collected using participant observation simultaneously on each unit.

The setting for the study was a large, metropolitan teaching hospital in Southern New England. The hospital has approximately 720 acute care beds, and provides comprehensive care with particular expertise in cardiology, oncology, neurosciences and orthopedics, as well as serving as the Level 1 Trauma facility for the surrounding region. The hospital conducts approximately 11,000 inpatient surgeries and 14,000 outpatient surgeries per year and employs over 1200 Registered Nurses.
Entrée to the two nursing units was provided through the Vice President for Patient Care. The Clinical Nurse Manager (CNM) for Pain Management, a PhD prepared Registered Nurse who conducts consultation for clients with complex pain management problems was critical in identifying appropriate units for study and in facilitating the researcher’s entry into the areas of study. As an insider, the CNM was in a key position to identify postoperative units of similar size, providing care to similar client populations, yet where nursing practice related to pain assessment was anticipated to differ. The CNM also assisted the researcher in negotiating the organizational IRB, and by providing an introduction to the Clinical Nurse Managers of the two units chosen for study and facilitating initial introductions to key staff nurses on each unit.

The two nursing units in the study share many characteristics. Because they are in the same organization, they operate under the same mission and philosophy. They are governed by the same senior nursing administration, including the Vice President for Patient Care and the Director of Surgical Nursing Services, and operate under shared nursing policies and procedures. Each unit has a Nurse Manager and Assistant Manager. The units are of similar size (twenty one and thirty beds) and operate under similar staffing patterns (day staffing of four to six registered nurses providing direct client care), and provide care to very similar client populations (mixed surgical population). However, the analysis also revealed several unique features of each unit related to nursing pain assessment.
Figure 1

Physical Layout of Unit A

practice. The next sections provide a more detailed description of these two nursing units.

Unit A

Unit A is a 30 bed surgical unit. The unit has been in its current location for just over one year, but the same staff and client mix moved as a unit from another building. Physically, the unit is best described as “upscale”. The walls are painted in shades of green and taupe, with muted wallpaper borders throughout. Stepping off the elevator, one gets the feeling similar to a midlevel hotel, as opposed to a traditional hospital unit. The physical layout of Unit A is presented in Figure 1.
Although a number of people – clients, nurses, doctors, learners from many disciplines, physiotherapists, case managers, move through the unit on any given day, the unit is surprisingly quiet.

The clients on Unit A come from a variety of surgical services, including: vascular surgery, plastic surgery, general surgery, bariatric (gastric bypass) surgery, thyroid surgery and trauma. The unit also received overflow clients from orthopedics and neurosurgery.

Twenty seven RN’s are employed on Unit A. The average age of RN’s on the unit is forty (40) years. Eighty nine (88.9%) percent of the nurses on Unit A are white, eleven percent (11.1%) are African American, and almost four percent (3.7%) are Asian/Pacific Islanders.

Typical staffing on the day shift includes six Registered Nurses (RN’s), four Certified Nursing Assistants (CNA’s), two unit secretaries and a unit assistant who is responsible for obtaining and managing supplies, distributing meal trays and accompanying clients to discharge.

A dry erase board near the elevators lists clients by room number and name, and for each client provides the name of the Registered Nurse and the Certified Nursing Assistant responsible for their care.

At change of shift, the RN receives report from the outgoing shift, by means of a “silent report”, a one page worksheet that describes the client’s diagnosis and history, and provides a description of all lab tests, procedures, dressing changes, mobility and diet orders to guide the nurse in planning care.
Nurses also receive some form of verbal report from the outgoing shift, on a one-to-one basis, although the amount and duration of this report varied widely.

Certified nursing assistants receive report from the RN and are responsible for taking client’s vital signs, and for providing basic hygiene and mobility care for clients. CNA’s are also expected to obtain a rating of the client’s pain (using a 0-10 scale) and document this information of the client’s bedside flow sheet once per shift.

Pain Assessment on Unit A

Following morning report, RNs typically prepare their morning medications at the Pyxis (medication distribution) tower, and then visit each of their assigned clients. On the day shift, a single RN will care for 5 clients. Before the RN sees the client, typically the CNA will have visited the client, assessed vital signs, and perhaps recorded a pain intensity score on the client’s flow sheet.

Typically, the nurse first examines the client’s bedside flow sheet, which is kept just inside the client’s room. The nurse then proceeds to approach the individual client for assessment. Details of this assessment will be discussed in the following section.

There is relatively little interaction among nurses on Unit A. The unit is widely spread out, and nurses have ample space to work, document, examine client records, etc. The hubs for interaction on the unit are at the secretary’s desk and the two Pyxis stations. At the Pyxis stations two nurses are frequently in the same space preparing medications for clients at the same time. The secretary’s desk is
where nurses tend to gather during ‘down’ times, and is where interaction with the attending physicians begins and ends. Interaction among the staff is generally pleasant and at a social level. Relatively little client-related consultation between nurses was visible, although nurses were generally willing to discuss client care issues with the researcher.

The attending physicians occupy a position of power on Unit A. Rounds by two of the attending physicians occur between seven and eight each morning. These rounds are a very important part of the day, and one of the Registered Nurses accompanies each of these surgeons on their rounds. On one occasion, Dr. G., a surgeon who has a number of clients on the unit at any given time, arrived on the unit at 7:45, complaining of his bad mood. One of the CNA’s poured him his morning glass of orange juice, and one of the nurses proceeded to draw a crown on his Styrofoam cup and remind him that he was the “King”.

More than one nurse described their pride that both of these physicians have requested that their clients only be admitted to Unit A. One nurse described:

*We’re elitists here. Our nurses are referred to as ‘the princesses’ and they like that.*

Keeping the doctors happy was a recurring theme on Unit A. Nurses described how difficult it was to care for clients who posed multiple challenges because they didn’t want to have to keep calling the doctors for new orders.

Nurses on Unit A describe that they see many clients who pose challenges around pain assessment. As one nurse described: *“We get a lot of drug addicts*
here”. Another nurse described her experience in caring for a client who was a
particular challenge in terms of managing his pain, by suggesting: “One patient
like that can rattle your whole day”.

Unit B

Unit B is a 21 bed surgical unit, located in an older building of the hospital.
Physically, in comparison to Unit A, Unit B is older, cramped and dark. The
ceilings are low, and the corridors are narrow. The paint is chipped in many
places, and poorly patched in others. There is relatively little space that is not
devoted to client rooms. The staff break room is a small space, approximately four
feet by eight feet that appears to have once been a supply closet. There is a great
deal of equipment stored in the hallways. The layout of Unit B is presented in
Figure 2.

The largest open space on the unit is a central nursing desk where the
majority of interaction occurs. This is also where client charts are kept and where
the secretary is seated.

Currently there are twenty seven (27) RN’s working on Unit B. Their
ethnic mix is as follows: Eighty nine percent (88.9%) White; Seven percent
(7.4%) Asian/Pacific Islanders; and almost four percent (3.7%) African American.
There is one male nurse on Unit B.
Typical staffing for the day shift consists of four (4) RN’s, three (3) CNA’s, one (1) secretary and one (1) unit assistant. The clients on Unit B come from a variety of surgical services including: vascular surgery, plastic surgery, general surgery, ear, nose and throat surgery, trauma and overflow clients from genitourinary surgery, orthopedics and neurosurgery.

A dry erase board across from the nursing station lists clients by room number and name, and for each client provides the name of the Registered Nurse and the Certified Nursing Assistant responsible for their care. One frequently has
to move the crash cart or the electrocardiogram machine, or a traveling computer in order to be able to access the board.

As on Unit A, at change of shift, the RN receives report from the outgoing shift, by means of a "silent report". Nurses also receive some form of verbal report from the outgoing shift, on a one-to-one basis, although, as on Unit A, the amount and duration of this report varied widely.

On Unit B, report is followed by a "Roll Call", conducted by the Clinical Manager or the Assistant Clinical Manager, and occurs at the central nursing station. At roll call, nurses discuss upcoming events, and present a variety of issues for discussion. These issues are not usually related specifically to clients.

Certified Nursing Assistants receive report from the RN and are responsible for taking client's vital signs, and for providing basic hygiene and mobility care for clients. CNA's are also expected to obtain a rating of the client's pain (using a 0-10 scale) and document this information of the client's bedside flow sheet.

**Pain Assessment on Unit B**

On the day shift, a single RN will care for 5 or 6 clients. Following morning report RNs typically begin their morning assessments. Nurses on Unit B visit each client before preparing morning medications for distribution. After this brief assessment, which almost always relates exclusively to the client's pain, nurses prepare their morning medications at the Pyxis tower. When medications are prepared, nurses return to each room to conduct more thorough assessments of
their clients. By this time, the CNA will have visited the client, assessed vital signs, and perhaps recorded a pain intensity score on the client’s flow sheet. This phase of assessment looks very similar to what occurs on Unit A. Typically, the nurse first examines the client’s bedside flow sheet, which is kept just inside the client’s room. The nurse then proceeds to approach the individual client for assessment. Details of this assessment will be discussed in the following section.

The hubs for interaction on Unit B are the two medication towers, and the main desk. Physician rounds occur at multiple points throughout the day, and the physicians are a relatively low-impact presence on this unit. Much of their interaction with nurses on Unit B occurs via the telephone.

The primary forms of interaction are nurse-to-client and nurse-to-nurse. Nurses on Unit B described themselves as a team, and were quick to point out which nurses were considered the “experts” in things like IV initiation, skin care, and pain assessment.

**Pain Assessment Habitus – Individual and Group – Units A and B**

The second research question addresses the specific strategies that nurses use to assess pain in each of these two fields (individual habitus). The third question deals with the predominant nursing pain assessment habitus in each of the two fields.

A unique pattern of nurses’ pain assessment practice emerged on each unit. For each unit, this pattern will be described through the detailed presentation of the pain assessment practice of one nurse who most clearly reflects the pattern.
Individual variations from the pattern will also be described. Individual data will also be presented to support the pattern.

**Pain Assessment on Unit A: Janet**

Nurses on Unit A described a strikingly similar pattern of pain assessment practice. This pattern will be described using the detailed description of pain assessment by one nurse, Janet (all names used throughout this presentation are pseudonyms). Janet has almost thirty years of experience as a Registered Nurse, and has worked on Unit A for more than twenty five years. Janet was observed over the course of an eight hour shift, and specifically during her assessments of two postoperative clients.

For Janet, assessment begins before she enters the client’s room. She described her review of the client’s medical record as the first phase of her assessment, focusing specifically on the client’s diagnosis and type of surgical procedure. She described how knowing the client’s diagnosis impacts her assessment of their pain:

> ...somebody who has bone pain, metastatic cancer to the bone...I find...in my hierarchy of things...would be one of the most painful things that a person could ever have, and I’ve never of course experienced that myself.

> Now, our patients who’ve had thyroid surgery, the night of the surgery, they do have, you know, pain that requires Morphine or Demerol or whatever’s ordered, but the next day they just go on Tylenol unless they have, like a drain in, or extenuating circumstances where they have to do a
mediastinoscopy of something, just straight thyroids, they just have Tylenol the next day and they don't have a great deal of pain, so it definitely depends on what they have done too... and being a nurse, and going in the Operating Room a couple of times, when I was a student, of course, to observe, I know how much they have to manipulate the bowel when they do abdominal surgery and that sort of thing, yes. And it depends on how long they were in the OR and it's a lot of factors. There's a young girl that was a trauma, that had to have her back, her lumbar area... and she also had an ORIF [open reduction and internal fixation, a type of fracture repair] of her leg, and she was in surgery for nine hours, so that would make a big difference too... how long the surgical procedure was... I think so too... yeah, I think the procedure that they have done, where it is. Patients, believe it or not, who have open heart surgery, in my experience, don't have a great deal of pain. I'm not saying they don't have pain, but in the hierarchy of things, there are things that are worse... patients who've had abdominal surgery... or patients who have a break, like in an old fractured ankle. The heart surgery patients don't have as much pain as patients who've had fractured ankles, or abdominal surgery, in my experience.

Janet approaches each client using her experience as a frame of reference for the current client's experience. She has developed a typology of pain experience which is based on the physiology of the client's diagnosis/surgical procedure. She has come to expect that the degree of a client's pain is directly
related to the surgical procedure that they have experienced and to the type of physical manipulation/changes that have occurred. As she described her initial assessment of an elderly woman:

I had to give her the heparin too in her abdomen, so I did get to look and see how large her incision is... just below the xyphoid process... you know... down versus across, and it wasn't a pubic incision, you know, so I got to look and see how large her incision is, so that's another factor that was playing into the part of how much pain she was... how far she was post op... her position changing... the type of incision that she had, so all those factors would play a part.

For Janet, assessment of pain in postoperative clients is primarily rooted in an understanding of the specific physiological experience of surgery. She has also developed a typology which is based in her experience with clients of different gender and age. She describes:

I find that the people that most have problems with pain control are people that have perhaps not had abdominal surgery in the past, but also younger patients have more problems dealing with pain. Young males, in my experience, have had more trouble, and I always kid them in a way. I mean, I kid the elderly people about being like John Wayne and I kid the younger people about... the males... that it's a good thing that males don't have the babies because there wouldn't be many babies...
From Janet’s perspective, other client characteristics are also associated with varying degrees of pain. For example:

*You know, usually they...people who are larger need a little bit more pain medicine*

Janet sees the course of postoperative pain as having a relatively predictable trajectory, which again is rooted in a typology of clients:

*...from experience, you know, patients who have had abdominal surgery generally need medication every, about every six hours...and you do...you do need to medicate someone before they get up ... before they have, maybe a respiratory treatment, or any kind of procedure...you know, that they’re going to go off, even to X-ray. You know they’re going to need some medication on board before they leave, before they start moving around. So, I guess, I guess experience makes a big difference.*

Specific client behaviors and manifestations of pain (evident criteria) are an integral part of her assessment, but are of secondary importance. Janet described her initial morning assessment of an elderly female client who had a small bowel resection two days prior:

*When I first walked in she was sleeping, so I didn’t, you know, so when I woke her up, I noticed that she wasn’t grimacing ... I did ask her how her night went. I think that’s important...to ask them how their night went...and then I asked her if she thought she needed anything for pain and I did ask her if she thought there was any problem...whether she was grimacing*
at all, the fact that she was sleeping was a good sign. If she were in pain, she'd certainly be awake...

Pain is a normal consequence of surgical intervention, and clients are expected to bear a certain degree of pain. Her assessment of pain is also based in her beliefs about how much medication the client should receive. Again, Janet described:

I'd already looked at her chart and seen that she'd been medicated around 2 a.m., so I already knew the...intervals between her last pain medicine and when I walked in the room...approximately how many hours it was. I thought that was important.

Janet perceives a pattern in the frequency with which clients should receive analgesics:

She had been about...she'd been approximately 6 hours without pain medicine, and...she was a larger woman, that you know, usually they...people who are larger need a little bit more pain medicine. But, in the same respect she'd gone six hours and that's about the interval that you know, is appropriate for pain management. And when she goes home, I expect her interval to be about the same.

Like every nurse interviewed on Unit A, Janet described the difficulties inherent in caring for clients whose pain is difficult to control. Nurses expressed concern about whether client's estimations of their pain can be trusted. Nurses
determine whether or not they believe that a client is credible in their description of their pain. Janet described her approach to dealing with these clients:

It is hard... it is hard... I guess... I guess, maybe I just keep calling the doctor and just let the doctor handle it... let the doctor come up and look at the patient and see what he thinks, and if the patient is... fabricating or if he truly thinks the patient's in pain. I let the doctor deal with it, cause they'll... because the other thing is, you wouldn't want to cry wolf... Let's say, let's say off the top of my head, you have somebody that has a cast on their arm or something, and they keep telling you how much pain they have... how much pain they have. Suppose there's something physically wrong with that limb that's in the cast, and you're giving this patient medication, medication, medication, but you're not doing something that's physically wrong. Suppose that cast needs to be cut... he has compartment syndrome... then maybe you should put it in the doctor's hands and you should tell the doctor to come over and assess the patient themselves, because what you're giving the patient, you know, after several, several attempts to control the pain is not working, then I guess I would put it in the doctor's hands and let them determine... I mean... I can even say to the doctor "I think that they're fabricating" or "I don't believe it, but I feel that you should make sure that there's nothing seriously going on with the patient"... a pinched nerve, or compartment syndrome, or you know something that I'm missing as a nurse that a physician could pick up.
Key Characteristics of Nursing Pain Assessment Habitus on Unit A

Janet’s description of her assessment highlights key characteristics of nursing pain assessment habitus on Unit A. First, pain assessment is rooted in a reference typology of clients based on diagnosis. Angela, a young nurse who has worked on this unit for one year, described how she has learned a typology of clients:

*I think...once you’ve been here for a while and you see the different surgical procedures, you expect a certain kind of pain...the thyroids [clients who have had partial or total thyroidectomy] ... usually no pain... if anything a sore, scratchy, irritable throat... and you just kind of learn to expect that with them, whereas you see abdominal surgeries you know... and depending on the type of surgery, you kind of know... you’re going to have a lot of gas pain... you might not have a lot of incisional pain, but the gas pain might be most painful for you. You know, you get to have a sense of what to expect.*

Abigail, a nurse with six years of experience on this unit described her typology:

*The tram flaps... because we were talking about that this morning. You know, they’ve had lower abdominal work, up into the chest. They’re crouched... they’re... they tend to have... one of their biggest complaints tends to be pain... [referring to clients who have experienced gastric bypass] ... it depends whether they have laparoscopic or open.... the laps*
seems to do okay with it. The opens... they tend to be in a little more pain.

I think it has to do with the size of the abdominal area and the pull on the incision site and that type of thing.... Thyroids... usually very minimal pain... usually most of them, their biggest complaint is a sore throat from being intubated.

Jane, who has worked on this unit for five years, provided another example of a typology of pain based on the client’s diagnosis:

I find that cancer patients... after they've got the diagnosis of cancer, their pain is higher... it can even be something as simple as a partial mastectomy... which isn't that simple but... compared to the other surgeries... and if they're dealing with you know, a biopsy report that they're waiting for... they have a lot of pain. I find somebody that's in poor health... you know, such as poor nourishment before surgery, I find their pain is worse...

Like Janet, other nurses on Unit A described a clear typology of client pain experience based on age. For example Abigail described:

Younger [ones]... I think they... there's a trend that their idea of pain... and I think that all has to do with experience... they seem to have a different view on pain. Basically, I think the young one's feel like they should be sedated... you know pain medication should keep them knocked out type of thing. I don't think the elderly ask for a lot of pain medication. I think that sometimes... not that we have to force it on them, but you have to
continually ask them...you know...just when they’ve had...you know, small bowel resections...and you know they have to be hurting...that type of thing...I think they’re least apt to ask for things.

Maureen, a nurse with 21 years of experience on this unit described similar typology based on client’s age:

The older folks seem to have a lot less pain than the younger folk, surprisingly. Even though we expect them to have the same equivalent. Maybe it’s because over the years they’ve learned to tolerate pain. But the younger ones seem to have a lot more pain.

Angela also described differences in pain based on peoples’ ages:

I think that with the elderly, it’s either one of two extremes. Either they’re in very, very little pain or they’re crying constantly in pain... That’s what I’ve seen. I don’t know... I think a lot of elderly people are under the thing that “I can’t take that. I’ll become addicted...I’m worried about taking it”, so you spend a lot of time suggesting and explaining that you really should try to take some pain medicine...the less pain you have, the more you can move...which is often the best thing for you...and I think they’re under that whole old school...and then some of them are the exact opposite...and I just wonder if it’s confusion and taking them out of their own environment, and surgery in itself that makes them just totally overwhelmed...yeah...I think it’s either one or the other.
Clients who differ from the anticipated trajectory for their particular surgery pose difficulty in pain assessment. Angela described:

*You know, a lot of times you deal with people who have past histories or chronic illnesses...you think, oh, this is a simple surgery, but each patient is different and because of their medical history the way you treat their pain is different from...dosing of medications can often seem like..."Oh my God, I'm giving this patient way too much"...but they're saying their pain is still at a 10, and I don't think people always consider that okay...this patient has a chronic illness, and this is what they take at home to handle their every day pain...now on top if it is the surgical procedure. I think that's a big, big factor.*

The nurse on Unit A enters the client room to conduct an assessment of the client with a series of expectations based on the client’s procedure, diagnosis, age, and perhaps gender. When assessing clients, nurses on Unit A rely on a variety of criteria, consistent with the categories described by Sjostrom. Both subjective (what the client says) and objective criteria (how the client looks, vital signs, etc) are considered, but when pushed to describe the most important criteria, nurses generally give primacy to objective criteria. For example, another nurse from Unit A, Mary, who has worked on this unit for three years, described the most important factors in helping her assess pain in a middle aged man who had undergone a parotidectomy the previous day:
... pretty much when the surgery was... what type of surgery he had


done... he had the parotidectomy... and his age... and whether or not he had

any surgery in that area beforehand... just his general body language. He

was sitting up... alert and oriented... vital signs were good...

Mary described her process of assessment for a man who had undergone

lumbar laminectomy the day before:

I looked at what day he had his surgery... what he had for pain med coming

out of the surgery, and what he’d been using in the last 24 hours... and I

also looked at his flow sheet before I even went in the door... checked his

vital signs... I was concerned because his pressure was elevated, so I

wanted to find out if he was in pain... and body language as well, and what

he reported.

Mary described the most important signs in her assessment of pain:

I would say the blood pressure and pulse, and what he self-reported his

pain level to be, and he was able to move very easily for me to check his

opsite... based on how he moved and what his pain level was I didn’t feel

as though I needed to medicate him at all for pain. Usually I ask them to

rate it on a scale of 1-10, but he clearly wasn’t even ratable. Usually, if

it’s 5 or more, I consider giving them something for pain.

Mary asks the client to rate the severity of his pain on a standard rating

scale, but the client’s rating is of secondary importance to Mary’s assessment of
his behavior and her prior knowledge drawn from clients who have experienced this surgical procedure.

Maureen described her assessment of an elderly gentleman one day following a small bowel resection:

_ I basically watched him to see what his face looked like; asked him how his pain was; watched to see how he breathed, how he moved and he said at that point he was fairly comfortable. He does have one of the patient activated machines that... what I was mainly trying to figure out was to make sure this was keeping him comfortable. And he was able to do all these things, and able to get out of bed and he seems to be doing okay. And also his blood pressure is not sky high. That would be one of the key things if he were in pain._

Again, objective criteria are given primacy in the assessment of this client’s pain.

Jane, who has worked on this unit for 5 years, described how she learned to assess pain in postoperative clients:

_ I oriented on this floor, so when I was first orienting, I would watch the way another nurse would ask a patient how they felt and describe it... and you know you always look for how they are relating to you... you know how they’re communicating with you... and what their body language is... , facial expression. You can tell a lot just by looking at them._
Jane described that sometimes pain does not present as one would expect based on physiology:

*I expected more pain in the abdominal area, I also expected more... she actually has a hernia... her diaphragm on one side... her bowel contents are up a little bit in her chest... I expected pain up there, but she’s never complained of it.*

Client reports of pain on Unit A are also subject to an *assessment of the client’s credibility* by the nurse. Nurses on Unit A expressed concern about whether clients were always honest and forthright in their description of their pain. Angela described how working on this unit has taught her about the behavior of clients perceived as drug-seeking:

*I think like through orientation you tend to pick up things like... sometimes there are people here that aren’t here for a real reason. They’re here because they’re seeking medication... and I think, kind of... the more experience you have, you get an understanding for who’s in pain and who’s not. If, you know the patient is saying to you, I can’t take this... and they are constantly turning and crying and everything, and you stand outside the doorway, you can sometimes catch them walking around doing stuff, and talking on the phone. You kind of get a sense for the variety of patients and who is true and who is not... by just observing them, watching them, keeping an eye on them... seeing how often they request... you know...*
For Angela, sometimes credibility is tied to the client’s age:

*Either young people want to get back to normal and get out of here or they’re milking it for everything... seriously...... some people do very, very well and other people... they just want to stay, and... you can tell that they could do a lot more and they don’t want to.*

Each nurse interviewed on Unit A volunteered that many clients were overestimating their pain in order to receive higher doses of medication (a behavior referred to as drug-seeking). Nurses on Unit A also expressed a concern for overmedicating clients. While initially this concern seems to relate to pain management as opposed to pain assessment, for nurses on this unit, the processes are deeply intertwined, and the danger of overmedicating a client clearly factors into the nurses’ assessment of how much pain the client is actually experiencing. Angela, a new nurse, described her dilemma in assessing pain in an elderly confused woman who had a bowel resection the previous day:

*She has a history that’s significant for CVA and aneurysms, and gets a little bit confused, and wasn’t even aware that she had had surgery... so I kind of just watch her facial expressions, because I don’t think she fully understands the whole 1-10 pain scale*

Interviewer: *She can’t do it?*

Angela: *She just... yeah... she’s not really getting all that, so I just basically watched how she moved and her facial expressions... and she’ll request pain med, and you’ll find her dozing off as she’s asking for it and she’s*
been so sleepy in the past that I've often held off on giving her...which...if she's sleeping and I'm approaching her and she's not even waking up...I'm not going to go and give her more...

Mary described the challenges in caring for clients with chronic pain:

It's...it's very time consuming and in depth and...it takes a long to time to assess really what their pain is from...and it also takes a lot of narcotics to control it and sometime you question your nursing judgment as to whether or not to give such high doses.

Abigail also described similar challenges:

I think a lot of it has to do with some of the medications they already take.

I think it depends on what kind of chronic pain. Some of them are, I think, more stoic and they don't require a lot, and you have the other end of the scale, where you just can't give them enough, and I think that has to do with...the same...with the medications they already take and what we are used to giving...

Again, Angela described:

Basically, I would say to use the pain scale, watch their vitals, and watch the patient. I would say those are the three biggest factors. And use your judgment. If, you know, someone's dozing off every two seconds and still requesting pain meds, you might need to hold off. You don't want to snow them too much and then be breaking out the Narcan [a narcotic antagonist].
The goal of pain management on Unit A is to promote client’s movement toward discharge. Maureen described that pain is an anticipated consequence of surgery. Clients are not expected to be pain free:

*His postoperative pain was under control which is one of our main goals, so he can get up and do these things. Basically, getting out of bed, using the incentive spirometer, and just being able to socialize with people and be able to talk coherently and not be in agony... because no one should have a lot of pain and no one should have a horrible post op- course.*

For Maureen, adequate pain control is manifested by a client’s ability to perform activities of daily living:

*I would have thought he would have had more pain than what he’s having, but he seems to be doing alright with that. There’s nothing that says... I don’t think he’s telling me the wrong thing. He’s able to function okay, and I think he’s fairly comfortable.*

Abigail described:

*If they’re saying that their pain is an eight out of ten. You might have had the same procedure, and you thought it was a two; theirs is still an eight and you have to treat it as such, and it’s as important as any other vital sign that we take, so that we can keep patients comfortable, and on the road to recovery so they can go home.*
Maureen: A deviation from the pattern

The following lengthy exchange is presented in order to provide one example of a significant deviation from the predominant pattern of assessment on Unit A. Maureen describes her assessment of a male client, with a long history of recreational narcotic use, who has had a complicated post operative course following hip surgery:

_I think he's really having a lot of pain. Again, a lot of it is... now we have the hip pain, the orthopedic pain and I'm not sure if positioning the leg would be really helpful or maybe just getting some of that fluid off that seems to be on there. No, he's very uncomfortable, and we give him the IV medicine and it doesn't work very well... or... let me rephrase that... it works well for a short period of time. I'd like to see him on something that had a longer duration on it, which means calling the physicians and asking if there's something else I can give to him._

Interviewer: _When you looked at him this morning, what kind of things did you see or hear in him that told you about his pain?_

Maureen: _I saw a man that couldn't move his leg, and he was able to... he wasn't able to sit up in the bed because it hurt too much, and he basically told me his leg was hurting him, and then trying to adjust it on the pillow and just trying to lift it, he was, like, in agony, and he still is to this time, you know, I just moved him a little while ago, and he's hurting and he's not_
pounding this one... it hurts too bad. He could probably use something like OxyIR or Oxycontin, but the physicians don't want to order it.

Interviewer: And you think that has to do with his history?

Maureen: I'm not sure if it's the history or just they don't believe this man can have that much pain. I find a lot of physicians don't think people can have pain. He's more... he fits more in the category of a chronic pain so he's going to need more than the person that just fell and has got the broken bone now (pause) I'll have to work on that one...hmmmm

Interviewer: What signs that he exhibited were most important to you?

Maureen: The inability to be able to sit up, and him saying he couldn't move his leg, and it hurt. Plus, having had him the last couple of days, I could see that we're not getting any place pain-wise and he really could... he told me it hurt; he told me he couldn't move and just looking at him. And his vital signs were okay, but sometimes that doesn't always tell you when you're in that pain. You know, if you've got somebody acutely in pain, yes... you would have the blood pressure way off, but he's not. He can't move, and if he can't move, that tells me he's hurting someplace.

Interviewer: Looking again at him, compared to other people who've had the same sorts of procedures... do you see his pain as being similar or different?

Maureen: Different, in that he's in a lot more pain and whether it's because he needs another surgical procedure... or infection... or what I
don't know, but he's in a lot more pain than what somebody from this particular surgery should be having.

Maureen's assessment of this client differs from the pattern in a number of respects. First, while Maureen clearly recognizes a typology of clients based on age and surgical procedure, this typology does not form the basis of her assessment of this man. Rather, primary consideration is given to the client's presentation. Secondly, the client's rating of his pain is considered, and Maureen moves beyond understanding of severity, to also obtaining data about the quality, character and duration of the client's pain. Most importantly, the client is believed. Maureen recognizes herself as an outlier on this unit:

Interviewer: ... and how do you think other nurses on this floor might approach the assessment of pain in someone like him?

Maureen: Not the same that I do. (Pause)

Interviewer: Okay, how would it be different?

Maureen: A lot of people would... or even have come across to say because of his drug abuse that he is seeking pain medicine. You know, he is on his substance that he needs for it [Methadone] and I've heard other people say that. (Pause)

Interviewer: And what do you think they would rely on in terms of getting a handle on his pain? What kinds of... if they would do it differently, what would they be looking at?
Maureen: Probably looking at him and figuring he’s not having that much pain ... that he’s just looking for something for a high.

How Is Habitus Maintained on Unit A?

A single focus groups session was held on each unit. The purpose of these sessions was to provide further understanding of any differences in nursing pain assessment practice between the two units and to begin to develop an understanding of how pain assessment habitus is both developed and maintained on each of the units.

On each unit, the session was conducted over the nurses’ lunch hour and lasted thirty five to forty minutes. On Unit A, six nurses attended. The session served to reinforce the findings of the individual interviews with regard to differences in pain assessment practice between the two units. On Unit A, nurses reiterated that a typology of clients exists based on diagnosis, and that this typology helps the nurse to understand what to expect for individual clients:

*We know the kinds of patients we have here... what they go through.... you get to know the surgeries and what they need ... the thyroids for example, even the discharge instructions tell them you shouldn’t need anything more than Tylenol...*

Nurses also described that they view the client’s description as a sometimes less than reliable indicator:

*...the person who’s saying “My pain’s an ten out of ten”, but they’ve been down to the cafeteria four times.... and their pulse is 60 and their blood
pressure's 120/80 and they're a 10/10...makes me look...and say...okay either you're on more medication than we know you've been on...and that's...well there's something going on...

Nurses on each unit were asked how the unit's method of pain assessment developed, and how it is maintained. In both instances, it was very difficult to get nurses to describe this process in any degree of detail. For the most part, nurses gave general answers describing the role of policies and preceptors, but were unable to provide a description of how habitus develops or is maintained.

On Unit A, the predominant form of pain assessment practice is rewarded by physicians: *We have doctors who only want their patients on this unit, and from client’s moving through the system: If they're doing well, and not overmedicated, they get up and moving.*

**Pain Assessment on Unit B: Alice**

Nurses on Unit B also described a pattern of pain assessment practice that is similar to each other, but different from the pattern observed on Unit A. The pattern will be described using the detailed description of pain assessment by one nurse, Alice. Alice has 5 years of experience as a Registered Nurse, but has worked on Unit B in a number of capacities, beginning as a unit assistant, for eight years. Alice was observed over the course of two eight hour shifts, and specifically during her assessments of four postoperative clients. Like Janet on Unit A, Alice’s practice exemplifies each of the key characteristics of pain assessment practice on Unit B.
For Alice, pain assessment also begins before she sees the client. In the following excerpt, she described her morning routine in preparing to care for a young woman who had sustained multiple fractures as a result of a fall from a ladder:

Well initially, I just...initially in getting report in the morning...I take a look at the patient's meds sheets, just to get an idea of how much they've required pain medication and it kind of gives you an idea of what...of how their pain control has gone...and I assessed that primarily that she was getting medicated every...well her order was written that she could be medicated every hour...with her prn med and also that there were times when she was requiring that but that the longest she was able to go was every two hours without pain medication. So initially, that's where my assessment starts, like in report in the morning.

For Alice, understanding the client's use of medication on the prior shifts provides a baseline understanding of their progress to date. In the client's room, Alice spent seven minutes at the client's bedside, discussing her pain. Alice continued her description:

And then, you know, I usually go in an introduce myself to the patients and sign their sheets and kind of just give them a brief overview to see how comfortable they are and what kinds of nonverbal cues they may be exhibiting at that time that may indicate that they're in pain.

Interviewer: And what kinds of nonverbal things did you see with her?
Alice: Well, initially, when I primarily went in early, early this morning, she was actually sleeping and then she reported to one of the CNA's that she was having pain so I went in. Usually, I like to get an assessment of the patient's pain before I medicate them, and when I actually entered the room in the morning after I had gotten report that she was having pain, and she was sleeping again, and I had to wake her up. I assessed her to be unable to really put any great pressure on her area of injury, so that was definitely important to pick up on and also that she was just very descriptive in the type of pain that she was having.

Interviewer: And what did she tell you about it?

Alice: Well, mainly she said that primarily she was concerned that the pain medication that she presently is on wasn't quite working for her. She said it was only... it was working for about an hour but it wasn't giving her great relief really in her opinion, and she also mentioned that she had had some... some problems with muscle spasms after I asked her, and during her assessment when I was looking at her med sheets, I noticed that she had been ordered for Valium... for muscle spasms, which is oftentimes a precipitator to pain... with patients... for patients with her type of injury, and I noticed that she hadn't been taking the Valium for a couple of days so all those things initially kind of gave me an idea where she was and what type of... patient, you know, as far as pain she would be for the day.

Alice uses multiple criteria, including her knowledge of clients with similar
injuries:

Considering her scheduling for her medications, I think that, I thought that she would have been getting some better relief. I think that’s the major difference. The muscle spasms that she reported that she was having was something that’s very common. Her description of pain is very similar to most people with the same type of injury. So, in terms of the type of pain she’s having...it seems to be the same as people, most people with her type of injury, but.... I don’t, it’s just the way she...the relief she’s getting is just, I don’t know, it seems a little different in terms of where she is and how long she’s been here.

Despite her use of multiple assessment criteria, the ultimate criterion is the client’s own description of her pain:

I think the most helpful was actually her rating of the pain...because going in...at times when the room was quiet, she was able to sleep so she wasn't exhibiting any nonverbal cues that would say this is a patient that was in [pain] but considering...I would say between her diagnosis and her injury and also what she verbalized as her pain being...I think those today were two of the most determining factors. And then further throughout the morning, getting an idea of what her history was, in terms of past injuries also.

Alice also uses a typology based on diagnosis, but this is of secondary importance to the client’s own description of their pain, and the objective signs she
observes. Alice described the importance of knowing the client and her history:

It was interesting when in talking to her and doing a brief assessment of basically meds that she was on in the past ... that she was on Valium at home... and she basically did have another injury that required her to take some pain medication and what her treatment for that was. And I think that, that plays a role in learning from the patient what works for them, what hasn't worked in the past and what they've done to maintain or to control their pain at home. I think that's... that's really important actually.

Interviewer: And in the case of this specific patient, what did that information make you think?

Alice: Well, it, it gave me information regarding what may not work. Already she knows in her mind that a certain medication will not work for her because she's already tried that, so if the doctors recommended that, which... the med she had taken at home is a typical med, then I would have been able to provide them with that information... and I think, you know when knowing that and her having had somewhat of an exposure to that medication, she basically knows whether it's going to work for her and if she doesn't feel it's not going to work... if she feels that it's not going to work, then most likely it won't, so that would be some information that I would share with the doctors.

For Alice, the goal of pain management is to promote her client's ability to accomplish activities of daily living, but primarily to provide comfort for
comfort's sake:

Like I said the most important thing I think patients have taught us... taught me... is that pain is pain and pain is different for everyone and their perception... and everyone's perception of pain is different, and... that basically it's something that you really... I think if we get patients at a comfortable level it just kind of helps their whole recovery period and everything that we are trying to do for them fall into place because they're more apt to do the incentive spirometer and to be out of bed and to not refuse that test. So it starts there... it really does. And a lot of the time, patients only know what they're aware of... what their senses are telling them. They don't know if their potassium's low. They don't know if, you know, a lot of the times, so a lot of the times, we're focusing on other things, but... the issue at hand is what they feel, and if they feel pain, that's really what they want addressed at the time... I think initially coming on to the floor, it's something that you just kind of learn to do as a new grad. You just get frustrated when you really can't get the result that you want so then, if you really are a seeker of knowledge and you really want to help your patients and like... there gets to a point where you really just exhaust a lot of measures and you'll go to everyone and say... and ask them for their opinions about what they can offer in terms of certain patients... the biggest lesson for me has been how I interact with the patient and helping them to feel comfortable and helping them to feel comfortable in the care
that I am going to provide for them. Addressing every issue and making it an important one because that’s... I think that’s very important in terms of when patients, when people are hospitalized because it’s going to be a scary thing as it is, you know... even scarier if you feel as though certain things are not given the attention they need... and I think pain is probably one of the most important ones.

Alice described the role of experience in helping her learn to assess pain in postoperative clients:

Well, mainly it comes from a lot of experience with patients who are in a significant amount of pain and really, like I mentioned before, really falling into a situation where you feel like, or the patient feels like they’re not being well controlled in terms of their pain and feeling like, you know, you just have really got to utilize other resources and tap into other resources to try to get this patient... to a comfortable level... which really, having to utilize all these other resources kind of... you kind of keep them in the back of your head... as to where, you know, if a patient is kind of progressing in one direction, you kind of say, well, okay well if this doesn’t work, I know I can always order a pain consult or recommend this. Or certain times, you know, you think to yourself, you know, if this isn't working and that isn't working there has to be a little more to the story, and that maybe leads you to kind of you know, try to go into a further assessment with the patient in terms of past injuries, past medications they...
may have been on, or I mean, realistically speaking, any other social issues...

Alice also described how she served as an advocate for her client, negotiating with the doctors for what she perceived as better pain management for this client:

*After I returned from lunch, the doctor called me and just basically let me know that she was going to be discharged this afternoon, which is something that was a little surprising for me for a patient who actually was out of bed for the first time yesterday and was still requiring pain medications every hour and still wasn’t getting any relief. So at that time, I… and I had mentioned to Mrs. Z. this morning that probably within the next couple of days or so the doctors were going to try to transfer her on to p.o. [per os; oral] pain medications.*

*At that time this morning they hadn’t yet done that, but I knew that considering the length of time she’s been here and the fact that she’s received her brace that that most likely was the next step… and… so I think the physician called me with the impression actually, what he asked me was her discharge paper work filled out and I kind of asked him, you know, to slow down for a little bit and I explained to him that she was still requiring the pain medication at least every two hours. She didn’t feel… it has been working for her but she’s still having pain, and most importantly we haven’t… we haven’t tried her on anything orally, which, if*
anything... here would be the best place to do that. You know, we wouldn't want to send a patient home, without at least having tried them on p.o. medications to see if they work. So, you know, he proceeded to ask me what did I think he should do, and I said well, you know, and he said, "Well, we can just write for some Oxycontin". So he gave me an order for Oxycontin and Flexoril, and at the time, you know. And he said, "Okay, and we'll be up to see her later". And I said,"Well, do we want to D/C [discontinue] the Dilaudid? Do we want to give her something for breakthrough?" and he said...you know, he asked me to D/C the Dilaudid and then he said to give her 5 mg. of OxyIR every 6 hours (sigh) so I asked, him, okay, how did he feel. I just basically told him what my assessment has been throughout the day, and what I feel, and I...I just told him that I didn't think that this was going to be adequate for this patient considering where she was coming from in terms of her pain medication, so he decided to write for 5 to 10 every six hours, so, you know, and I just told him that we would definitely go ahead and try that, but...I don't know if that will be ...if that will give her the best relief.

Alice also described how other nurses on Unit B assess pain in postoperative clients:

I think definitely they, we all pretty much approach it the same way, in terms of, you know, going by what the patient's rating of what their pain is. A lot of times, I think a lot of people... rely on nonverbal cues, you know, a
lot of times people say I baby patients too much (laughing), but you know, because another nurse may have approached it differently if they, you know, heard their patient rating pain at eight, but every time they went in there, they were sleeping, so but I think pretty much we all approach it the same way in terms of taking great consideration into the fact that the patient is reporting pain and that they, that what their injury is and the fact that they are going to have a significant amount of pain with it, especially her injury.

Alice described the importance of nurse-to-nurse consultation in the assessment and management of pain.

We have so many different levels of nurses here, people who’ve been here for years, people who’ve worked in different aspects of nursing so you get a good idea in terms of... certain patients and certain diagnoses, in terms of getting other people’s opinions. So sometimes when you just feel like, you really don’t know what else to do for a patient it’s good to get other people’s opinions on what the best... you know, the best choices are for this patient in terms of pain management, but we do it all the time, just because sometimes when you are kind of overwhelmed by your day or your assignment it’s very easy to kind of miss the obvious and you know, not tap into some of the resources that you would with a clear mind. (Laughter)

Key characteristics of Nursing Pain Assessment Habitus on Unit B

Alice’s description of her assessment highlights several of the key
characteristics of nursing pain assessment habitus on Unit B. While, en face, this pattern looks similar to that described on Unit A, there are key differences. For nurses on Unit B, the single-most determining factor in assessing a client in pain is the client's own description or narrative of this pain. Several nurses described how the client's rating is the most important assessment criterion. Kathy, a nurse who has worked on this unit for only two weeks, described this:

*The big thing is the pain scale. It's not you who is having the pain. You can't say this person doesn't look like they're in pain. You've got to go by what they say... his rating of, like the pain scale, like when you explain the pain scale to them... just to see where his level is, you know because that... you can have a person that could be in severe pain at six or someone at ten with a severe. It depends on the person.*

Janice, who has worked on this unit for 17 years, described the importance of listening to the client's narrative, and emphasizes that there are important characteristics of pain beyond severity that merit assessment:

*I really need to listen to them... really listen... their verbal... I need to listen to them... it's probably the most important. It's really hard to decide because I do use... you know, the body language, the facial expression... you know, and whether they're a little mobile in the bed... to kind of get a good idea... mostly it's listening to the patient and what they're telling you.*

*You've got to listen to the patient. I mean you can do as much as you can by asking them, you know, on a scale and whatever, but you really*
need to push it further than just getting a number out of them... tell them to
describe it... push it... tell me more about your pain.

Beth, a nurse with 5 years experience on this unit, described her belief,
prominent on Unit B, that the client is the ultimate authority regarding their pain:

More so from experience than... I mean I always go on whatever the patient
tells me. I don't care what they... if they... so much as re-educating them
whether or not... some don't want to take narcotics... so you have to go
through that whole schpeil... letting them know what you're aiming at. If
the patient says they've got pain, then they've got pain, and it's not for me
to judge it.

Beth also described her use of multiple assessment criteria in conducting an
assessment. Beth described her assessment of a client:

Just asking him where his pain was... what it was like... was it being
covered... how he was uncomfortable. It was more so his belly... and then a
little bit... you know... from some of his fractures.

Interviewer: Of all the things you did with him this morning and the things
you saw, what signs and symptoms were most important to you in getting a
handle on his pain?

Beth: What he said

Interviewer: And what did he say?
Beth: He said that he had pain on his right side. He had complained about that... that it was a dull, continuous pain. He rated it. I don't remember the exact number. I think it was 3 and a half... 3.5

Interviewer: He was pretty specific wasn't he?

Beth: Yeah, very specific... he said he was uncomfortable in his belly. His belly’s very distended. I felt his belly... saw how that was... and he got a Fleet [enema]... had a bowel movement.

Natalie described the importance of using a numeric pain scale as one element in a comprehensive assessment:

What I tell the patient is like, okay so the number helps me to know, for instance, do you get two Percocets or one? And...and then for them... I say... if you do that while you’re here... thinking about your pain as a certain level, when you go home, you’ll know do I take one or two. Because that’s usually how it’s written: one to two.

Kathy described how she combined the client’s rating of the pain severity, and description of the character of pain, her observation of physical criteria, and her knowledge based on experience to help her understand her client’s pain:

He was rating it between a three and a four... And it’s worse with movement, and where they want to get him up in the chair and walk, it’s only going to get worse, it’s not going to get better... he was guarded a little bit when he washed up. When we first, you know, stood up, he kind of guarded the area where his incision was
Nurses on Unit B also describe a typology of clients based on diagnosis, procedure or age, but this typology is used for secondary referential value when assessing an individual client. The assessment of this client as an individual is primary. For example, Alice described a typology based on clients’ age:

*I think that older people or maybe elderly people are more... their perceptions of pain are a lot greater and they wouldn’t like to be in pain, but now, recently I’ve just started to realize that how educated society is about pain and the medications and a lot of the... our older population really try to grin and bear it because they don’t want to get on some of these medications that they’ve seen in the news that may be addictive and they may... may develop a tolerance to, so you can see sometimes that a lot of the times they don’t ask for pain medication just with that fear in mind.*

Kathy described a similar typology:

*I think some of the older patients don’t ask for it as much. I think they’re afraid that they’re going to get addicted to it. I find that I have to ask them more often “Are you in pain?” Whereas the younger ones, they’re more... they’ll push their button and say “I’m in pain”*

Darlene described how one client, a man recovering from severe burns to his torso and upper extremities, differed from her expectations of pain in someone who has been burned:

*Well... the fact that he said he didn’t have any [pain]... so he outright spoke about it because otherwise, because he was a burn patient, I think it’s very*
rare that I’ve seen burn patients who are not in pain, so... He appeared comfortable to me. He had a smile on his face. He was very, very pleasant to speak to this morning. He wasn’t wincing. He didn’t outright say, “I need my pain medication”

Janice’s approach contrasts with that described by nurses on Unit A:

I don’t judge pain by the way other patients with a similar diagnosis... I think each individual is different... and you really need to listen to those cues that they give you.

Nurses on Unit B, use multiple criteria when conducting pain assessment, but the client’s own narrative is the ultimate criteria. Gabrielle described:

Interviewer: Are there times when a patient’s verbal rating and the physical cues you see don’t jive?

Gabrielle: Mmm hmmm (affirmative).

Interviewer: And what happens then?

Gabrielle: I go with what they say...

Darlene described how she believes other nurses on Unit B would assess pain in postoperative clients using multiple criteria:

I think they would... they would be very attentive, and they would, well, based on my experiences observing other nurses are, they give pain medication readily. They ask people if they’re in pain. I just basically have many role models here where I see... They go in, they ask the patient about their pain, they do their full assessment, they get quality and
duration and...what they’ve used in the past, so they do full assessments. They are quite...quite keen on delivering effective analgesics to the patient. Like nurses on Unit A, nurses on Unit B do not expect clients to be completely pain free:

And I’ll tell them, like three is kind of like... we know you’ve had this accident or this surgery and there’s going to be discomfort and maybe there’s some positioning or ice packs or whatever that we can give for you...but anything... like...they’ll say “My pain is a six or a seven, but I’m okay”, and I’m like... ”well, no, you’re really not okay if you’re saying that’s what it is”. So, the number scale, and then the thing to come back after a certain period of time to say “Did this work for you?”. Because I know there’s people like that girl I was describing earlier... that it can go on for days if somebody’s not going to do something about it and say... it’s not supposed to be like this.

Nurses on Unit B also described the importance of knowing this individual client in helping them to perform accurate assessments. Janice described the importance of having some kind of baseline on which to base her assessment:

I just saw this look, and then I just saw the shoulders shrug... and he said, “Well, I’m really not in a whole lot... I really need it only to sleep”, so it really looked like his pain was in control, and saying that his body just aches... so there were more verbal cues... but also just looking at his body
language. I knew him from Friday night... and what God awful pain he was in on Friday night, and trying to get him regulated, to today which was totally different end of the spectrum, so... I mean he moves fine in bed, and just the way he shrugged and didn't grimace... he didn't... and you know... he didn't have his hand clenched, you know... on the button. Yeah, so it was more of the body language and the verbal...

Interviewer: Now, how much did knowing him from Friday help you today?

Janice: Oh... absolutely... I kind of knew what his baseline was and then what he went through......on Friday and......

Interviewer: What did he look like then?

Janice: On Friday?

Interviewer: Yes.

Janice: Ah... he was just flat in bed... trouble breathing... which did require two chest tubes because he had pockets of fluid bilaterally so he did get two chest tubes... with a resident... a first year resident... trying to put in chest tubes at the bedside, with a fourth year resident right there, so... it was a little difficult for him.

Darlene described how having baseline knowledge of this client helped her to provide care for a young man recovering from burns. She described how her assessment of this client was enhanced by having known him on previous days:
Oh yes... he had been immediately post operative, or post burn shower... so he was in quite a bit of pain. Movement... any bit of movement that we did to reposition him caused him quite a bit of pain... I think it had been a couple of hours since he'd had his last pain medication. He was shivering. He was just generally uncomfortable. He felt quite cold. I hadn't looked at his vital signs because he wasn't my patient at that time, but ah... yeah... he appeared very much uncomfortable and he had high, high pain levels...

He needed something. He had mentioned it also to K [another nurse]... so.....

Interviewer: And you saw him present very differently this morning obviously?

Darlene: Yeah, it was easy to tell how he had been and how he is now... and to see the change... yeah.... his voice, his facial expression.

He... he looked a lot different back then... so.....

Knowing a client provides a baseline for subsequent assessments. Kathy described her perception of a change in the client over the course of a morning:

So, I like start.... to address it, because earlier this morning he had no pain.

Now I know from the couple of hours I had him he went from no pain to three to four.

In the absence of knowing the client from a previous shift, Janice makes use of colleagues:
Actually I use my own colleagues too. I use my own colleagues... people that might have had them... the shift before even... to compare their pain and do a quick assessment before they leave... for the next shift.

If the client is unable to provide information about themselves, the family may provide important clues. Janice described:

Sometimes from the family... if I notice something that's odd... not necessarily to say with him... but if I notice something and... a lot of times I'll ask the family.... if there's a wife, or a mom or something... like... is that normal for him... or... you know... to try to get an idea. It could be a mannerism... it could be... you know... to try to get a baseline... so family's been very helpful.

Natalie describes the importance of developing a pain management routine that is right for the specific client:

And you have to tell people that, you know, they need to take the pain medicine in order to breathe right, get up and move, you know, and do all those other things. Otherwise, they're going to lay there stiff as a board, you know... so frequently you have to tell people it's okay to have the pain medicine... it's okay to say it's not working in between the times that the dosage is written for, and then when somebody's newly postoperative, you tell them, "We don't really know yet what's going to manage your pain, so we just need to know and if it's not right, we'll change it".
And I'll usually tell them, when somebody's able to understand the way it would be written, like...for instance if somebody gets something around the clock and then there's a breakthrough, and then there may be a secondary breakthrough, you know, and that this is the usual...protocol of how it's given, but if that's not right, that we'll be adapting that. So, I try and tell them so they'll understand what their options are and why we choose certain things. For instance, people would usually prefer their Dilaudid IV all the time because they get the immediate relief, but then later, you know if you explain, what that may be is our third option if other things aren't working.

Contrast Angela's (Unit A) earlier assessment about a sleeping client to the approach described by Natalie:

You can't, I don't know...you just have to be able to see them at a comfort level and...like today...I'm orienting someone, and so she said that, "Well I just gave him his Oxycontin but he's asleep. I woke him up to give him the pills and he says he has a lot of pain, but he's sleeping". I said, "Well, you know...a lot of people just are dealing with it, and they've got to sleep at some point, so that's really not the best indication", and I knew he was a problem pain management person from the other day, and I couldn't remember the details of it, but we looked back and he had not had any kind of breakthrough pain medicine during the night, so yeah, in the morning, he's probably tired and in pain and ready...so I said well you know...and
we gave him the OxyIR 5 mg and then the other thing at the same time, and so it's okay to give them. It's not that much of a dose, and by the time the Oxycontin kicks in...

In contrast to Unit A, nurses on Unit B made no reference to overmedicating clients. Also, on Unit A, poor pain control was often described as an issue belonging to the client and related to a question of the client's credibility. On Unit B, nurses saw poor pain control as a problem belonging to the physicians. For example, Gabrielle described the difficulties inherent in providing care for clients with outside of hospital drug use:

\[\text{Once in a while we'll get a few that...they might have been at home with 180-240 mg. of Oxycontin or something and then they come here and the docs put them like on 40 or 50, but most of those times, it's just getting the doctors to write the right order. The challenges you face mostly is getting the doctors to write something that's right for them.}\]

While nurses on Unit A describe their concern of overmedicating prescribing, nurses on Unit B describe the opposite. Natalie explained:

\[\text{That's how a lot of them are, that the doctors are wanting to move them along, you know, off their IV, or off their PCA kind of thing, and get them to be ready for discharge, but if things aren't working...they're not working... But I think we also have a lot of people that can't talk, and can't tell you or can't provide a rating scale... they just don't get it, and so you using all those other cues and...I find more often the problem is that}\]
they're not... that they don't have enough pain medicine ordered for us to be using, not that it's too much. I never really see that.

Natalie described how new Nurses on Unit B come to develop a comfort level with administration of large doses of pain medications:

Well I think in the beginning they're a little bit afraid of the pain medicine... narcotics... and... it's you know... so I think you come with that, ... but then... you just see it. You feel like you're giving somebody a lot of medicine and they handle it well, or it's not touching their pain, so then you're not intimidated by the drug per se and you're watching more the response. We did have somebody the other night that came back postop from... she had... like a hernia repair, but... had gotten several boluses of Dilaudid downstairs, so we had just gotten her up [from PACU] and were doing our postop checks and her respirations were down, like to 6, but she was talking, and so you know, we just like, she had a PCA, and we just held the PCA and called the doctor, and she was like, "Do I need to come?" and I was like, "No, she's talking, I think she's alright. We'll just held the PCA for a while" So we monitored her, and K [oreintee] was doing that, and so I just kind of left her, and I said, "just stay in there... and keep up with the q15 [every fifteen minutes] and then q30 vitals and so her continuous and her PCA were off about an hour and a half and then she was complaining of pain again, and her respirations were up and I think they came to 18 or something like that, so then they started her back on just
the PCA dose, not the continuous, but it wasn't something really that
happened here on the PCA, it was a response from downstairs, so that was
our one experience of ...

Interviewer: That was a learning experience for her...

Natalie: Yeah, because I mean the numbers told you, this is really bad, and
even the doctor saying do I need to come, and I'm kind of like, well no,
she's talking and she's okay... but we could have called her back at any
point... I think... and then we see people with a lot of pain, and you
can... it's written all over their faces... You can tell they can't do anything,
so you have to... you have to treat them...

Natalie described the collective habitus for pain assessment on Unit B:
I think we're pretty liberal with the pain meds, which most people are fine
with postoperatively. You know, when it first happens, we're okay with
being very liberal... so that's sort of routine around the unit. You never
really question something if it's around the clock or q2 [every two hours]
or most of them q4, but then you get those, you know, you don't really
question that so much, PCA's so... I think... it's the mindset of the whole
unit. Well this is how it is here. And we don't really concern ourselves
with pain medicine. Like sometimes I'll hear... other nurses either when
they float in or whatever, and you'll hear... but I don't really hear too much
of our staff talking drug seeking. It comes from more medical people, who
come in, and they'll say that about someone. But here, if we've had
somebody with a big surgery or a big injury, we don’t call that drug seeking. We'll have people with drug histories, that our medicine isn’t working right for them just yet, and then we get a higher doses. Like we were talking about this little girl with Oxycontin at 80 mg., well then someone else could have 200. So when you’ve given higher levels, it puts it in perspective about what somebody needs.

Beth described the conflict between doctors and nurses:

I always let my patients know if you’re not being covered for your pain, or if your pain gets worse... even if it’s before time... you let me know. I tell them I love calling doctors and irritating them we’ll get in under control.

But even if it’s beforehand, then let me know...

The process of negotiation with the physicians isn’t always smooth:

I keep paging... I keep paging them... telling them they’re not being covered... you need to do something... and if they aren’t willing to do anything I go above them

Natalie describes the difficulties in working with physicians:

Well, and it’s the nurses, it’s not the doctors, because a lot of times the interns will, you know, that’s pretty much who we’re dealing with, and they’re just coming in for their rotation...

Interviewer: They’re passing through?

Natalie: Yeah, they’re passing through so it’s not like they’ve spent so much time with this type of clientele and we’re telling them... we need
this... and then they... you call them and you hound them and you tell them and you get the medicine that the patient needs. Very rarely will they not agree, or they've got another reason. Like, every now and then it will be that they're watching a symptom... and they don't want to mask the symptom... but that's kind of uncomfortable for everyone, but that doesn't happen that much. But if, sometimes, if there is an issue, there's either J. to call, or M. or just go up over that particular intern's head to the resident or higher and you'll find somebody that will agree with you, you know... and back you up.

Nurses on Unit B described pain assessment as a very client-specific and client centered process. They described wanting to provide care in a manner that they would want to receive. Natalie described her motivation for pain assessment:

Well I think that... If you can see that they're in pain and you can't really take that, okay?

Kathy described a similar point of view:

So, when I see a patient, I mean, when something's not being done, I get frustrated because I say, if that was my Dad, or if that was my Mom, you know, what would I try to do for them?

Natalie described that the motivation for vigorous management of pain, however, is not entirely altruistic:

It also, just the selfish part of it... in managing my day and me getting through my day... and the tasks I need to accomplish... I can't have
somebody crying in pain because I’ve missed a dose or that somebody timely didn’t respond. So there’s that selfish motivation of, for me to get through everything I need to do, they need to be comfortable. Otherwise, they’re at you all the time... or the family... you know, you can’t get anything done because you’re always... so... I think that’s probably another reason behind the nurses on this unit being very assertive with the doctors is like... if you’re always dealing with somebody’s inadequate pain medicine, you can’t move on and do anything else.

Darlene described the difference between her previous place of employment and Unit B:

Mmm hmmm, yeah. Actually this unit is very much a QA [Quality Assurance] unit for pain control. It’s very, very... in fact, I think here, of any place that I’ve been to, they’re very much... very readily able to provide analgesics for pain control... to assess... They always want people to be assessed with their pain levels with their vital signs. pain levels... always have to find out what their pain is like.

Darlene described how she learned about acceptable pain assessment practice on this unit:

During my orientation, Alice taught me, you always assess their numbers, their levels, even before you give out your oral medications; you want to make sure that they are comfortable. That’s the first thing that you check on during shift change is that you make sure that they’re comfortable. You
make sure that they don’t require any further interventions before you give
out your pain medication, or your oral medications because then you can
call the doctor immediately, get something, have that added to their pain
regimen and then carry on from there...

Janice described the process through which new nurses on Unit B learn to
assess pain:

Their preceptor is going to show them how to do that. And I’ve noticed on
this unit that those assessments are taking quite a long time. It’s not that
there’s anything wrong with that, but they’re getting that skill down. And
the more that they do it, the quicker they’ll be. But I have noticed...
actually... the last three new grads that I’ve had... they’re sitting at the
bedside... just talking to the patient and getting information from the
patient... so... and that’s what we encourage. I mean if something else is
going to slide, the preceptor is there to pick up, so that’s a skill that we
really try to foster.

This individualized assessment and liberal use of analgesics is not without
difficulty:

I can give you an example of a patient is K. down in 81. I don’t know if
she’s still there today because I was off yesterday, but she was a car
accident, young girl with a trach [tracheostomy] and a very badly
damaged foot, so she’s going to need multiple surgeries, but she’s also a
pain management problem. She likes the Dilaudid IV and... I think she got
up to 80 of Oxycontin. Hated the OxyIR, and always was wanting her
Dilaudid and not that p.o. And she was sort of getting ready for rehab,
and it’s like, well, you know, and I forget where I was going with this... but
......... so... her mother’s a nurse... doesn’t tell you right up front that she’s a
nurse, but you find out she’s a nurse and... like, so for days it’s like...she’s
been on this q2 hour 1mg. Dilaudid push thing that’s very time consuming
for us, but not really working well for her either, and so we tried the OxyIR
and she didn’t want it, and I explained to them that I thought the problem
was she didn’t have enough Oxycontin underneath to hold her over for the
OxyIR to work, and so then the Dilaudid IV... I just tried to explain...this
isn’t how it’s supposed to be, that every two hours you’re crying and we
come in and fix it for fifteen minutes, and then you’re crying again... and it
was going on for days... and when you come in and find that situation, it’s
like... it’s not supposed to be like this. It’s not that I don’t want to give you
the medicine every two hours, but it’s not supposed to be like that... so just
because you say “Well, but I’ve been getting it every two hours” or that
I’m the bad guy not wanting to give the IV, that’s not the point. The point
is it’s supposed to be better controlled this many days out. So like in the
beginning, I think it’s okay to say we don’t know you and we need to find
the comfort level, but after a certain point, every two hours on a general
unit isn’t okay. So she’s a pretty good example of trying to work this whole
thing out.
Clients with history of drug use: Alice’s experience

The following long excerpt from an interview with Alice describes her experience when precepting a new nurse, who was caring for a client with a history of drug use. This exchange serves to highlight the difference in approach to these clients between the two study units. She begins by describing the behavior of Kathy, who as a new nurse during her orientation period, was working under Alice’s preceptorship.

She really was having a difficult time being able to assess the patient in Bed one, because he was a patient who I think when we started taking care of him was about two days post op and he was getting up, getting into the chair, and by the time we had taken care of him for three days, and he was... he was still on IV pain medications every three, two to three hours and still rating his pain an eight, an eight, an eight after the medications and then, with further assessment, you know, she came to find out a lot of things about this patient who just basically liked us a lot, but as opposed to Bed two who... actually had a history of being... we were at a point where this gentlemen, with bed two he had actually been on numerous meds. He had been on Dilaudid PCA, the Vicodin he absolutely refused and... actually, I went in with Kathy and you know, we D/C’d his PCA and they ordered Vicodin and I said, you know, until we actually receive the Vicodin, I didn’t want to D/C the PCA, so I went in and I spoke to the patient and I let him know what medication he was going to be on and
automatically he... he knew the Vicodin wouldn't work and he wanted to leave if that's what they were going to prescribe and at that point, I asked him what... has he taken medications for pain before and he stated that he did, and I asked him which ones, and it's at that time he stated, you know, the combination of medications, the two medications that made up Percocet and what doses worked for him, so at that point, I knew that this was a person that had a significant, significant pain issues in the past because he was very knowledgeable about the medications, so it was at that time, again, you try, you know you just take the information for what it is and we brought that back to the physicians and then the physicians ended up ordering Percocet, but not in the doses that this patient thought would work for him, and then further down the line, in him and Kathy's relationship, he was able to divulge some things to Kathy that really played a big role in how we were going to treat him here because it's just the reality of, you know, of our profession where we're not always going to get the nice prim patients that we read about in our nursing books...

You know there's always going to be some deviation from the norm. ... and he was able to give Kathy information that... well, that was pertinent to his situation, the reason why we couldn't understand why he wasn't getting any relief with the meds was because he's been medicating himself at home, and he said, "I know what he's going to do. He's going to write me a prescription for Percocet", and he said "He's going to write it to
take...he's going to write it for me to take every four hours as I need it, but
he's like "I'll be done with half the prescription by the middle of next
week.". So, and at that point, you know Kathy was his primary caregiver,
and she was orienting with him, and I told her to spend a little extra time
with him and to get a good of, you know, what his history is.

And at that time she was able to get us a lot of information that...
you know, was beneficial in treating him and honestly, with that
information, I realized that maybe the doctors may have not been looking
at it from that standpoint and that's when we consulted the pain consult
team

Interviewer: And then what happened?

Alice: Well, B., who's wonderful, came in to see him and...she talked to
him at length and he was very open with her which was wonderful and he
was actually very eager to meet her and he was really happy he spoke to
her. And she was able to recommend some things to him in terms of
medications that may work and was able to speak to him about the
importance of taking them as prescribed, and he was definitely able to
verbalize an understanding of that, and she was able to pass that
information along to the doctors, and they basically sent him home with
her suggestions, so hopefully...

Interviewer: And what do you think Kathy learned from that experience?

Alice: Well...I think she learned that like I said that it's not always like the
case studies that we got in school. There's always variations. There's always deviations and if we're looking for the answers and we're not quite getting them, there's always ways to get them, you know, without making the patient feel uncomfortable... and letting the patient know that the information they're providing is just going to help us to give them better care, and I just think it was a wonderful learning experience for her because, by our third day with him, you know, she was doing a lot of stuff with him, and he was very open with her and was able to give her a lot of information, and interestingly enough, this is kind of a side bar, but he said, he said, he actually said to Kathy “I'm a recovering addict, I've been clean since 1987, but I smoke marijuana every day”, and I just thought this was the perception of adolescents that marijuana wasn't an actual drug, and I told Kathy that, and I said, that's interesting to look at that he would say that, and he said also that “The Percocets, I take till the pain is gone” and it's like, so where do you kind of go from here?...So, and having...I was thinking about writing a social work consult on him but the doctors just wanted to get him out that day. And actually, I think it was because of Kathy and I that he didn't send him home the day before because they just wanted him out of here.

Kathy, the new graduate, described her perception of the same experience: [He] was very hard to control pain-wise. You know, we gave him everything the doctor had ordered. On top of that, we would call the
doctor, and, you know, his level of the pain meds that he was getting was very high

Interviewer: Do you remember what he was getting?

Kathy: He was on Oxycodeone 16 mg. bid. He was on OxylR 10 mg. every four... every four hours he could have that and he was also having a breakthrough dose of the MSO₄ [Morphine Sulfate] 4 mg. IV. And so, we would give him his Oxycodone, the OxylR... didn’t touch his pain. We tried him on Percocet which didn’t touch anything. We tried him on Vicodin, which didn’t... he refused Vicodin... and then, as we learned with that patient, after the first day, you know the doctor would up his dose, and we gave him another stat dose of MSO₄... and he seemed to think that that helped a little bit, but... his pain was up... I mean, this patient, you walked in the room and you knew he was in pain.

Interviewer: Because?

A: His expression... He wouldn’t move, he wouldn’t eat... he would move when you asked him, but he was more to the point, I think he was more frustrated to the point that he was in so much pain, getting no relief, he just wanted to go home, so every time a doctor came in, “I want to go home”. And then, so we would call for the physician so that they would do the stat dose. The next day when I came in they were giving him like a sleeping pill overnight, and know of his pain medication would stop, so by the time the morning came, he was in such awful pain, nines and tens again, with no
relief. So then, I took it upon myself to call the pain nurse... to have her come in and assess him... so she had some more suggestions, different suggestions other than the Oxycodone, whereas the morphine was slightly working. she had suggested...MS Contin, instead of Oxycontin... she suggested a different thing for a headache... (unintelligible)... but it's like, you know, that was like a step in the right direction, at least, that we could, like, initiate that and I felt like at least we were trying, rather than just having the patient sitting there, and the doctor saying he could go home...

Interviewer: ... hmmm

Kathy: Because then I would feel like we didn't really try anything to do anything for his pain. So, I mean the pain consult was my... that was basically my first experience... which was wonderful. And the way that she went in... come to find out, ..., I think a lot of his pain control issues came to his prior drug abuse... which he confided in me that morning. But I think that's why his levels needed to be higher, but he never disclosed that to anybody before that, so you know, he probably could have had higher doses that what he was getting whereas we think he was at high doses, but for that particular patient, it really wasn't.

Interviewer: So he taught you a lot, about...

Kathy: Yes, whereas my preceptor, she kind of was more of... she picked up on it more than I did because, when we had suggested the Vicodin or Percocet, he knew what it was made of. He knew the milligrams, he knew
the doses, and that, for her, was a key to pick up on ... he’s had problems in the past, he’s you know. He might be a user or something to that effect. I think I’ve explained that.

How is Habitus Maintained on Unit B?

As on Unit A, a single focus group was held with nurses on Unit B. The session was held over the nurses’ lunch hour and lasted approximately forty (40) minutes. Seven (7) nurses attended the session, which was intended to provide further understanding of any differences between the two units in terms of pain assessment practice and to begin to develop an understanding of how nursing pain assessment habitus is both developed and maintained on each unit.

Nurses on Unit B described the importance of the client’s description of their pain. One nurse on Unit B summarized the process of pain assessment this way:

We take the patient at their word.

Another described:

We take the time ... the more you talk to them ... the more you get ... they’ll tell you ... when I move this happens ...

Another nurse on Unit B reinforced the importance for this group of viewing pain from the client’s perspective:

You put yourself in the patient’s shoes. If I’m lying in the bed, what’s the most important thing to me ... getting my light answered and getting my
pain meds... What's more important to that patient right now, his Colace and his multivitamins, or his pain meds?

Nurses agreed that there was common approach to conducting pain assessments on this unit. One nurse described "There's a mindset here about pain management."

Another said: "There is a way of doing things here". Another said: "it just becomes the way you do things".

One new nurse on Unit B described the process this way:

little by little ... you go ask one nurse... they give you more education... you carry that with you... and then you approach another situation, where maybe you didn't do so well with a pain control issue... you talk to somebody else... they give you another little bit of information... you're better qualified to handle pain medication for the next patient.

Nurses were asked what would happen to a nurse whose practice was significantly different from other nurses on the unit. One nurse described:

I don't think it would be possible. It wouldn't be accepted between your peers.

Another described succinctly: We would fix them. Yet another nurse described her experience with nurses whose practice was different than the norm on Unit B:

We did have a nurse that did not like to medicate for pain... who's no longer here... and it was a problem.... 'cause I can remember when I first
came here... and I’d work second shift... and you’d follow her... and she’d not medicate all day long... and these are post op patients.... You all know who I’m talking about... and she never liked to medicate for pain. Actually there was two... there was an LPN too.... but now I think everybody’s on the same boat....

Another nurse described an incident with a nurse (who no longer works on the unit) when she was told that her client was complaining of pain:

..and she said..”I just gave them something”. I said, “Well you better get something more”. Just like I said... I’d keep telling her you need to get them something else until she did it...

Nurses on each unit described the acquisition of capital for practicing in a way that’s consistent with the unit norms. A nurse on Unit B described:

Patients are more appreciative....because you sit and listen to them...so they’re thinking “oh good, there’s something going to be done about it”... they’re more inclined to do things....you develop a better relationship....and they trust you. They know you’re going to follow through with it....

Summary

Using data obtained through observation, individual interviews and small group discussions, nurses described the process of nursing pain assessment practice. A clear pattern of pain assessment practice was demonstrated on each unit, and these patterns were different from each other. On both units, nurses used
criteria from three sources: the client's description of their pain, the client's presentation and the nurses' experience with similar clients.

Where the practice was different was in the nurses' primary orientation toward pain assessment. On Unit A, the nurses approached each patient with a frame of reference based in their previous experience. Nurses filtered data obtained from all three sources through this frame of reference.

On Unit B, the primary frame of reference was the unique experience of each individual client. Again, nurses obtained assessment data from all three spheres, but primary importance was given to the client's own description of their individual experience.
CHAPTER SEVEN

THE PAIN ASSESSMENT INVENTORY

The Pain Assessment Inventory (PAI) was the principal data collection tool in Phase Three of the study and was used to assess for differences in nursing pain assessment practice between the two study units.

Nurses who were interviewed for Phase two (n=20) each completed the Pain Assessment Inventory (PAI). As previously described, the PAI was also distributed to all Registered Nurses working on each of the two study units. On Unit A, an additional twelve (12) surveys were returned, to yield a total sample of twenty two (22) or eighty one point five percent (81.5%) of the nurses on Unit A. On Unit B, an additional eight (8) surveys were returned, to yield a total sample of eighteen (18) or sixty six percent (66.7%) of the nurses on Unit B.

On Unit A, the total number of nurses completing the PAI was twenty two (22), which represents eighty one point five percent (81.5%) of the Registered Nurses Employed on Unit A. The nurses tenure as an RN ranged from five months to thirty five years, with a mean of over eleven (11.51) years. Half of the nurses were employed full time and half of them were employed part time on Unit A.

On Unit B, eighteen (18) nurses completed the PAI, representing sixty six point seven percent (66.67%) of the nurses currently employed on Unit B. The nurses had experience ranging from nine (9) weeks to thirty (30) years as a Registered Nurse.
Table 5

Demographics of Quantitative Sample

<table>
<thead>
<tr>
<th></th>
<th>Unit A</th>
<th>Unit B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tenure as RN (in years) - mean</td>
<td>11.51</td>
<td>10.25</td>
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<tr>
<td>Tenure as RN (in years) – range</td>
<td>0.4-42</td>
<td>0.17-30</td>
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<td>Tenure on this unit (in years) – mean</td>
<td>8.17</td>
<td>9.81</td>
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<tr>
<td>Tenure on this unit (in years) – range</td>
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<td>0.06-30</td>
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<tr>
<td>Status – full time</td>
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<td>10 (55.5%)</td>
</tr>
<tr>
<td>Status – part time</td>
<td>11 (50.0%)</td>
<td>6 (33.3%)</td>
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<tr>
<td>Status – per diem</td>
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</tr>
<tr>
<td>Status – no answer</td>
<td>0</td>
<td>1 (5.56%)</td>
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</table>

Demographic characteristics of the sample are presented in Table 5.

Descriptive statistics for the Pain Assessment Inventory are presented in Table 6.

Mean scores for each of the three variables of interest were high. In this sample, nurses used the client’s narrative of pain most frequently to assess pain in postoperative clients. This was followed by evident criteria, and then use of a reference typology.

Reliability

Those nurses who participated in individual interviews completed the PAI twice: once following their assessment of a client, and once following their

Table 6

Descriptive Statistics for the Pain Assessment Inventory

<table>
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<tr>
<th></th>
<th>N</th>
<th>Mean</th>
<th>Std. Dev.</th>
<th>Range</th>
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<td>Evident Criteria</td>
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<td>3.0-5.0</td>
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<td>Reference Typology</td>
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<td>0.9801</td>
<td>1.0-5.0</td>
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</table>
interview. This allowed for the assessment of test-retest reliability of the instrument in this sub-sample (n=20). Reliability coefficients (r_{tt}) for the subscales of the PAI in this sample are:

1. Client’s Narrative: .80340
2. Evident Criteria: .91431
3. Reference Typology: .91019

Discriminant function analysis was performed in order to assess the degree to which it was possible to predict nurses’ unit affiliation on the basis of their choice of coping strategies. While this analysis failed to yield significant results (Wilks’ lambda = 0.9492, F=0.64, df=3, p = .5928), the analysis was able to classify sixty three percent (63.64%) of the nurses in Unit A and fifty five percent (55.6%) of the nurses in Unit B correctly on the basis of their choice of assessment strategies.

Table 7 presents the mean scores for each variable by unit. Again, in both units nurses all three types of coping strategies, and used the client’s narrative most frequently, followed by evident criteria and the reference typology. In this sample, there were no significant differences between the two units on the mean

<table>
<thead>
<tr>
<th></th>
<th>Unit A</th>
<th>Unit B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client’s Narrative</td>
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<td>4.8333</td>
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<td>Evident Criteria</td>
<td>4.5445</td>
<td>4.2778</td>
</tr>
<tr>
<td>Reference Typology</td>
<td>3.6932</td>
<td>3.3889</td>
</tr>
<tr>
<td>Distracters</td>
<td>3.4318</td>
<td>2.8194*</td>
</tr>
</tbody>
</table>

*difference between means significant at p < 0.05
scores for each of the variables of interest, there were trends which support the findings of the qualitative analysis. For example, on Unit A, the mean score for use of the Client’s Narrative was lower than Unit B, and the mean score for Reference Typology was higher than on Unit B. Again, these trends are in keeping with the findings of the qualitative analysis, which suggested that nurses on Unit A were more likely to assess their client’s pain against a typology based on their previous experience, whereas nurses on Unit B were most likely to rely more heavily on knowing this specific client, and their description of their pain.

It is interesting to note that the only significant difference between the two units is that nurses in Unit A were significantly more likely to cite their use of strategies that are unrelated to pain and were included in the instrument as distracters. Potential reasons for this are discussed in Chapter Eight.

**Profile Analysis**

In order to develop a further understanding of the constellation of assessment criteria used by nurses in each unit, profiles of assessment criteria were developed. For each nurse, scores on each of the three dimensions (distracters were not used) of the PAI were classified as low or high. The nurses’ scores were calculated using the mean scores for their unit. For example, a nurse was classified as “Low Evident Criteria” if his or her score was less than the unit mean on this dimension (4.5445 on Unit A; 4.2778 on Unit B) and as high if his or her score was equal to or greater than the mean. This analysis was completed for each of the three dimensions.
Table 8

*Distribution of Nurses by Unit across Pain Assessment Profile*

<table>
<thead>
<tr>
<th></th>
<th>Unit A</th>
<th>Unit B</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>LLL</td>
<td>4 (18.18%)</td>
<td>1 (5.56%)</td>
<td>5 (12.5%)</td>
</tr>
<tr>
<td>LHL</td>
<td>1 (4.55%)</td>
<td>0 (0%)</td>
<td>1 (2.5%)</td>
</tr>
<tr>
<td>LLH</td>
<td>2 (9.09%)</td>
<td>2 (11.11%)</td>
<td>4 (10.0%)</td>
</tr>
<tr>
<td>LHH</td>
<td>2 (9.09%)</td>
<td>3 (16.67%)</td>
<td>5 (12.5%)</td>
</tr>
<tr>
<td>HLL</td>
<td>1 (4.55%)</td>
<td>4 (22.22%)</td>
<td>5 (12.5%)</td>
</tr>
<tr>
<td>HHHL</td>
<td>3 (13.66%)</td>
<td>6 (33.33%)</td>
<td>9 (22.5%)</td>
</tr>
<tr>
<td>HLH</td>
<td>2 (9.09%)</td>
<td>0 (0%)</td>
<td>2 (5.0%)</td>
</tr>
<tr>
<td>HHH</td>
<td>7 (31.82%)</td>
<td>2 (11.11%)</td>
<td>9 (22.5%)</td>
</tr>
</tbody>
</table>

This analysis yielded a possibility of eight (8) profiles (LLL, LHL, LLH, LHH, HLL, HHL, HLH and HHH). For example, a nurse whose scores were high for Client’s Narrative and Evident Criteria, and low for Reference Typology would be classified as HHL. The distribution of nurses across the eight profiles is presented in Table 8.

Across the sample, the majority of nurses fall in the “High” category for Client’s Narrative and Evident Criteria. What appears to differentiate the two units is the nurses’ scores on Reference Typology. Figure Three provides a representation of nurses’ distribution across categories.

The largest proportion of nurses on both units (45.48% on Unit A, and 44.44%) on Unit B, fall in the upper right quadrant of this diagram, defined by high use of the Client’s Narrative and high use of Evident Criteria, what differentiates these nurses from each other is their use of Reference Typology. In this quadrant, the largest proportion of nurses from Unit A (31.82%) are high users
of Reference Typology, while the largest proportion of nurses from Unit B (33.33%) are low users of Reference Typology.

Across all profiles, a larger proportion of nurses on Unit A (59.11) are categorized as high users of Reference Typology than nurses on Unit B (38.84).

**Summary**

A sample of forty (40) nurses from the two study nursing units completed the Pain Assessment Inventory. Nurses from both units described their use of data from all three spheres (Client’s Narrative, Evident Criteria and

*Figure 3*

Assessment Profiles of Nurses by Unit
Reference Typology). Statistical analysis failed to demonstrate significant

differences in pain assessment strategies used by nurses in the two units, with the
exception that nurses in Unit A were more likely to cite their use of criteria that are
unrelated pain assessment (distracters). Trends in the data, although not
statistically significant, are consistent with the findings of the qualitative analysis.

Assessment profiles were calculated that categorized each nurse as high or
low in their use of the three spheres. The largest proportions of nurses on both
units were categorized as high users of both the Client’s Narrative and Evident
Criteria. On Unit A, a greater proportion of nurses were classified as high users of
the Reference Typology sphere than on Unit B. Again, these findings support the
analysis of the field data.
CHAPTER EIGHT
DISCUSSION

This study used Bourdieu’s theory of practice as a lens through which to examine nurses’ pain assessment practice with postoperative clients. This theoretical framework suggests that individuals, embedded in practice as a social phenomenon, develop and maintain ways of behaving that are both practiced and condoned in the specific field in which practice occurs. For Bourdieu, the individual in practice, and the field in which practice occurs are in constant relationship with each other, in such a manner that the field shapes the practice of the individual, and the practice of the individual helps to shape the field.

While Bourdieu’s work has been widely influential in the study of practice within a number of disciplines, this study represents the first time it has been applied to the study of nursing practice. Bourdieu’s approach represents a different frame for the examination of nursing practice. Bourdieu melds both theory and method to provide a novel approach to the study of sociological objects. Wacquant [Wacquant, 1992 #100] suggests that Bourdieu’s approach to sociology consists of:

not a theory stricto censu so much as a sociological method consisting essentially in a manner of posing problems, in a parsimonious set of conceptual tools and procedures for constructing objects and for transferring knowledge gleaned in one area of inquiry into another. (p. 5)
According to Bourdieu (1989, translated by Wacquant 1992), the purpose of sociology is to "uncover the most profoundly buried structures of the various social worlds which constitute the social universe, as well as the 'mechanisms' which tend to ensure their production or their transformation" (p.7). Further, it is the task of the researcher to "decode the unwritten musical score according to which the actions of agents, each of whom believes she is improvising her own melody, are organized" (Bourdieu, 1908; translation provided by Wacquant)

This study involved the use of Bourdieu's concepts and relational statements as well as Bourdieu's approach to method in an attempt to develop an understanding of the nature of nurses' pain assessment practice with postoperative clients in two surgical nursing units in a large metropolitan teaching hospital. Discussion will follow the use of Bourdieu's three foundational concepts – field, habitus and capital.

Field

In Bourdieu's theory of practice, the concept of field differs from traditional conceptualizations of environment or social context. The field is defined, in part, by structural relations between agents, and consists of more than simply the location of action. Each field has its own history and logic of action. Agents occupy positions within the field, which are determined by the type and degree of capital which they possess.

The field is a space of both conflict and competition. Within the field, agents attempt to either preserve or change the form of the field, and to gain
control of the species of capital exchanged within it (Wacquant, 1992). Each field possesses its own history and logic of action.

The two nursing units described in this study were each conceptualized as fields of nursing pain assessment practice. It is again necessary to remind the reader that for the purpose of this study, analysis of these two fields of practice was limited to nurses’ pain assessment practice. A number of agents operate on each of the fields, but there actions are not of prime importance in understanding nursing pain assessment practice. In each of the two fields, there were nurse managers, assistant managers, case managers, physiotherapists, occupational therapists, nursing students, unit secretaries and unit assistants who were present on the units, but whose presence was not of central importance to the phenomena under study, nursing pain assessment practice. It is also important to note that in both units, while Certified Nursing Assistants play a structured role with respect to pain assessment (obtaining an intensity rating from clients and documenting this on the client’s bedside flow sheet), they do not play a central role in the nurses’ assessment of pain in postoperative patients.

In Unit A, the major agents with respect to nursing pain assessment practice include nurses, clients, attending physicians, and medical learners (medical students, interns and residents). In Unit B, the predominant actors with respect to pain assessment practice are the same as those encountered on Unit A – nurses, clients, attending physicians and medical learners.
Actors within each field have varying degrees of power and control over the field. With respect to pain assessment practice, nurses occupy a position of power which is greater than that of the client, because, in both settings, the client is dependent on the nurse for both assessment and management of pain. However, in Unit B, clients possess a form of capital (see next section), which affords them greater control of the field than clients in Unit A.

On Unit A, physicians occupy a prime position of power, and possess the most important forms of capital. However, using Bourdieu’s lens, this is not viewed solely as the agents in power exercising domination over agents with less power. In Bourdieu’s relational view of practice, agents who are dominated collaborate in maintaining those forces which perpetuate their domination, and that because both the structures of the field and the dispositions of the habitus are so historically ingrained in the field (structure) and embodied in the individual (habitus), that they are invisible to agents in practice. He suggests:

If it is fitting to recall that the dominated always contribute to their own domination, it is necessary at once to be reminded that the dispositions which incline them to this capacity are also the effect, embodied, of domination. (Bourdieu, 1989, quoted and translated by Wacquant, 1992, p. 24)

On Unit B, physicians occupy a position of less power than on Unit A, and are more peripheral to the nurses’ assessment of pain in postoperative pain. The nurses on Unit B also described a hierarchy of position that begins with the
medical learners (medical students, interns) and progresses up to the attending physicians. Nurses on Unit B use this hierarchy to their advantage to obtain necessary pain relief for their clients, and frequently described the process of going "over the head" of various levels of learner to obtain appropriate analgesic orders for their clients.

Bourdieu suggests that an understanding of practice within a field is dependent on an understanding of that which exists as capital within the field.

**Capital**

Capital is the currency operant within a field. Possession of capital determines an agent’s position within the field and allows an agent to exercise influence over the practice of others. As described earlier with respect to agents, there are forms of capital which are operative in both fields, but which are not central to an understanding of nurses’ pain assessment practice, and these agents and forms of capital were not addressed in this study.

For nurses in Unit A, three types of capital exist. The first, and most immediately obvious is recognition by colleagues. Nurses perceived as efficient and organized receive reward from both colleagues and the nurse manager. The second form of capital is verbal reward from physicians. Nurses receive verbal reward for providing care in a manner that enhances the client’s movement through hospitalization with the minimal amount of deviation from the norm. The third, and potentially more powerful form of capital exists as cultural capital, in being recognized as an ‘elite’ nursing unit. This form of capital was evident in the
nurses' description of their unit as highly skilled and specialized, and in the pride they demonstrated that their unit was the first choice of certain physicians.

In Unit B, there were two predominant forms of capital that relate to pain assessment practice. The first was intrinsic reward for clients whose pain was well managed. This form of capital was the least tangible form of currency observed on the two study units. Nurses expressed the reward they perceived from ensuring that clients were comfortable. On this unit, the more challenging the client's presentation with respect to pain, the greater the reward as perceived by the nurse. The second form of capital operative on Unit B, and the more obvious of the two, was reward from nursing colleagues and was based on being seen as a pain assessment "expert".

In keeping with Bourdieu's theory of practice, the types of capital operative within each field were anticipated to shape the practice of individual actors within the field, and to serve to maintain and or discourage particular modes of practice. The distribution of capital within a field determines the location of agents within the field.

In Unit A, one powerful form of capital (as it relates to nursing pain assessment) is possessed by the physicians and distributed to the nurses in the form of reward for clients' smooth movement through their hospitalization, with relatively little disruption to the physician. For clients whose trajectory is relatively well defined, and whose pain is easily controlled, this poses no difficulty for the nurse. However, clients whose pain is greater than anticipated, or who
have contradictory assessment findings that fall outside of the predicted path pose a dilemma for the nurse. If the nurse accepts the client’s narrative of pain at face value, this requires the nurse to access the physician for a change in orders and may even present a disruption from the normal flow of clients through the unit. Accessing the physician outside of their normal rounds on Unit A causes the physician to withhold powerful forms of capital (verbal reward and cultural capital) operant on this unit. It is not surprising therefore, that on Unit A clients whose pain assessment falls outside of the expected trajectory pose a problem for the nurses, and the problem is attributed to the client. Attribution of the problem to the physician would require the nurse to practice in a manner that is inconsistent with the structure of the field. Maureen, a nurse who operates outside of the predominant structure of the field is perceived as an outlier by both her own assessment and the assessment of other nurses on the unit. As such, powerful forms of capital are withheld from her.

In contrast, on Unit B the most powerful forms of capital relate to the nurse’s recognition as an ‘expert’ by peers. For these nurses then, caring for clients with complex pain management issues presents a potential opportunity for acquisition of capital. On this unit, then, clients with complex pain issues are perceived as an opportunity. The nurse uses a variety of resources in order to assure the client’s comfort. Physicians are simply one of the resources available to the nurse in their care of the client, and often a barrier to adequate pain management, as opposed to powerful sources of capital. It is understandable then,
that when nurses on Unit B perceive that a client’s pain is inadequately managed, the problem is often attributed to the physician’s inadequate orders for analgesia. On Unit A, complex pain assessment issues are a source of a problem, and from the nurse’s perspective, the problem is rooted in the client. For nurses in Unit B, the problem is rooted in the physician’s inadequate treatment of the client’s pain.

**Habitus**

Bourdieu (1977, 1980) identifies a major thrust of his work as an attempt to bridge the false dichotomy between approaches which suggest that human practice is determined either by structure or by agency. His use of the concept of field and analysis of structural relationships within the field addresses objective issues. Issues of agency are addressed through his use of the concept of habitus. For Bourdieu, the habitus is a series of dispositions to operate in certain ways which is embodied in the individual, and operates at a preconscious level. Dispositions of the habitus develop as a result of immersion in the field, and through exposure to forms of practice which are perceived as both appropriate and successful. Agents practicing within the same field are expected to display similar dispositions of the habitus. Bourdieu frequently used the analogy of the development of a ‘feel for the game’. Through repeated exposure to practice in a given field, an agent develops a preconscious awareness of those forms of practice which are possible and likely to be successful. When practicing in their own field, agents are generally unaware of the operation of the habitus. However, when practicing in a field where the predominant habitus is different than that of the individual, the
agent feels as 'a fish out of water' and then decisions regarding modes of practice operate at a much more conscious level.

This study was developed on the assumption that similar dispositions of the nursing pain assessment habitus (a collective nursing pain assessment habitus) would be visible on each nursing unit. What was not anticipated was the degree to which this collective habitus would predominate and be visible to the researcher. Through observation, individual interviews and small group interviews, a predominant pattern of nursing pain assessment practice on each unit emerged. Data obtained through use of the Pain Assessment Inventory, while failing to demonstrate statistically significant differences between the two units in this small sample, did demonstrate a trend which supported the qualitative findings. Individual nurse’s pain assessment practice was remarkably similar to other nurses on the agent’s home unit, and strikingly different from practice on the other unit under study. While individual variations from the pattern were identified, they were, for the most part, relatively minor. In the one instance where a nurse demonstrated a major deviation from the collective habitus on the unit, her experience served to highlight the strength of the predominant pattern.

In both units, nurses used data from three sources to assess pain in postoperative clients. The nurses’ use of each of these sources of data is grounded in a particular perspective. For example, the use of the client’s narrative of their pain is rooted in the perspective that pain is an individual experience; unique to this individual and their circumstances, and that the client is the ultimate authority
on his or her pain experience. Use of evident criteria for assessment is rooted in
the belief that clients who are experiencing pain exhibit behaviors that are
indicative of pain. Finally, use of a reference typology is undergirded by the belief
that client’s pain experience has a well defined trajectory. This trajectory may be
defined by the client’s age, gender or the surgical procedure that they have
experienced.

The nurse processes data from each of these spheres through a lens or filter
which is rooted in the nurses’ particular perspective or orientation in order to
arrive at an assessment of the client’s pain. This process is depicted in the model
presented in Figure 4.

Figure 4

Model of Nursing Pain Assessment
Pain Assessment Habitus on Unit A

On Unit A, the goal of pain assessment is to promote the client’s movement through their hospitalization and toward discharge. This is consistent with the forms of capital which are operant on Unit A. On Unit A, nurses have constructed a typology of clients’ pain experience which is based in the client’s surgical procedure and age. Clients are expected to manifest a certain severity of pain which is based in the physiological experience of the surgery itself. A well-defined trajectory exists for the majority of clients on this unit. Clients are expected to exhibit certain severity of pain (and to receive relief from commonly prescribed doses of pain medications). Deviations from this trajectory are perceived as problematic, and the problem is rooted in the client. This is consistent with earlier work by Fagerhaugh and Strauss (1977), who suggest that clients with unpredictable or unfamiliar trajectories pose problems for management and are least well served by the traditional health care system. It is worthy to note that this reality continues to exist over thirty years following the work of Fagerhaugh and Strauss.

The quantitative data, while not statistically significant, do demonstrate a trend which supports the qualitative analysis. The mean score for nurses’ use of “Reference Typology” as a criterion for assessing pain in postoperative clients is higher on Unit A than it is on Unit B. This finding supports the data obtained through the interviews.
It is also interesting to note that nurses on Unit B were significantly more likely than nurse on Unit A to report the use of assessment criteria that were not related to pain assessment (the distracter items on the PAI). One possible explanation for this finding is that the nurses on Unit A perceive themselves as doing holistic or comprehensive nursing assessments. The focus on holism and use of comprehensive sources of data is well ingrained in nursing discourse. However, in this instance, the use of multiple sources of data may also reflect the inability to conduct a focused assessment, and may reflect the nurses value of holism more than it reflects their actual practice in pain assessment.

Assessment on Unit A is rooted in the nurses’ knowledge of these well defined typologies of clients. Nurses approach individual clients using the typology as a yardstick. Having formed an expectation based on the typology, the nurse approaches the assessment of the individual client using a variety of criteria, including how the client looks, what the client says, and the client’s rating of the severity of their pain. However, each of these factors is assessed as a deviation from the “typical” client. This model of assessment reduces the individuality of the client to their distance from a perceived “norm”. Primacy is given to ‘objective’ manifestations of pain over the client’s rating of their pain. Further, severity of pain is the predominant subjective data. Less emphasis is placed on the nature, duration and character of the client’s pain. Again, the qualitative data do not suggest that nurses on Unit A use more “Reference Typology” strategies than they do “Client’s Description” or “Observable Criteria”. The quantitative data,
reflect the nurses' perceptions of how frequently they use a particular assessment
criteria, but what these data do not represent is the primacy of a particular
orientation or lens as the basis for assessment. This aspect of nurses' pain
assessment is clearly demonstrated by the qualitative data.

Next, data obtained from the client is subject to the nurses’ assessment of
the client’s credibility. Clients with a prior history of drug use, and to a lesser
extent, younger clients and clients with chronic pain are generally perceived as less
credible sources.

Figure 5 represents a model of nursing pain assessment habitus on Unit A.
Nurses on both units use the same three criteria, in relatively close to the same balance (in terms of frequency); the key difference is which criteria assumes primary importance, so that data obtained through the other two spheres are filtered through the first, and that the PAI can’t measure this.

**Pain Assessment Habitus on Unit B**

On Unit B, nursing pain assessment is rooted in an understanding of this client as an individual. Nurses use a wide variety of assessment criteria including the client’s rating of pain severity, the client’s description of the nature, character and duration of pain, how the client looks, the client’s previous history of injury and medication use. Nurses on Unit B also describe a typology of client based on surgical procedure and age, although this typology is of secondary importance in assessment. Finally, for nurses on Unit B, assessment is intimately tied to a process of intervention, and then reassessment and negotiation with physicians to obtain a pain management plan that is tailored to the needs of the individual client. For nurses on Unit B, it is more difficult to separate the process of assessment form intervention, and the process is more circular than linear. A model of nursing pain assessment on Unit B is presented in Figure 6.

**Summary**

Using multiple sources of data, this study resulted in the development of a model of nursing pain assessment practice. Nurses collect data from three spheres, including the client’s narrative of his or her pain experience, evident criteria and a
reference typology based on experience with clients in similar situations. These data are subjected to processing through a filter or lens constructed by the nurse’s particular orientation or perspective with respect to pain in postoperative clients.

On each of the two units under study, a predominant nursing pain assessment habitus emerged. While nurses on both units collected data from all three spheres, the filter through which these data were processed was different between the two units. On Unit A, data are filtered through the nurses’ perspective that clients have a well defined pain trajectory that can be predicted on the basis of the client’s surgical procedure, age or gender. On Unit B, assessment is rooted in the nurses’ perspective that pain is a unique individual experience.

Figure 6
Nursing Pain Assessment on Unit B
CHAPTER NINE

CONCLUSIONS, IMPLICATIONS AND LIMITATIONS

The purpose of this study was to conduct an in-depth examination of nursing pain assessment practice in two postoperative units in order to gain an in-depth understanding of nursing pain assessment habitus framed within Bourdieu’s theory of practice and to develop a descriptive model of nursing pain assessment habitus.

Use of Bourdieu’s theory has provided an alternative lens through which to view nursing pain assessment practice. The study has resulted in the development of a descriptive model of nursing pain assessment habitus (Figure 4), and has also produced a survey instrument (The Pain Assessment Inventory) which extends previous work on nurses’ pain assessment strategies (Sjöström, 1995; Sjöström et al., 1999; Kim & Sjöström, 2000), and which, with further refinement and testing, has potential applicability in the ongoing study of nursing pain assessment.

Limitations of the Study: Quantitative Data

Generalizability of the findings of the quantitative data is limited by a number of factors. First, while response rates compare favorably to other similar studies, it is possible that some self-selection bias may have existed in the sample. Nurses who chose not to respond in either the instrument development sample, or the study unit sample may differ significantly from the respondents in their choice of nursing pain assessment strategies.
A second issue relates to the instrument itself. The Pain Assessment Inventory was developed specifically for use in this study, and while the factor analysis supported its use to assess three dimensions of nursing pain assessment habitus, the sample size for the factor analysis was of borderline size. Further refinement and testing of the instrument in a larger sample is planned.

With respect to the study units, no statistically significant differences between units were demonstrated. However, the size of this sample (n=40) was very small to attempt to uncover differences of relatively small magnitude. Similar analysis in a larger sample (i.e. two larger nursing units) might be expected to yield different results.

**Trustworthiness of the Field Data**

Issues of credibility of fieldwork were discussed in Chapter Four, but certain issues merit further discussion. Because this study involved application of a well-established theory in a previously unexamined field, there was a concern that the researcher would see what was expected to see. Several strategies were adopted to attempt to reduce this possibility.

First, the data from both observation and interview were recorded immediately upon return from the field each day, and then were subjected to a first, atheoretical, reading. The purpose of this reading was simply to attempt to identify those pieces of data which provided new information about the setting or about practice, without regard to their usefulness to the theory. Only on second reading were data examined in light of the theoretical framework.
Also, the data were shared with a member of the dissertation committee who has less intimate familiarity with the theoretical framework. This reader also first examined the data in light of their ability to illuminate the settings and practice within the settings, and then secondly in light of the theoretical framework.

Finally, analysis of the data was shared with a key informant in the organization, without discussion of the theoretical framework. The purpose of this process was to enhance the researcher's confidence that the findings accurately depict practice in the field. This process lends additional credibility to the findings of the study.

**Implications of Bourdieu's Theory of Practice for Knowledge Development in Nursing**

This study used Bourdieu's theory of practice as a theoretical lens through which to examine nursing pain assessment practice on two nursing units. In keeping with Bourdieu's methodology, the study used multiple data collection methods. This method proved useful in illuminating different aspects of nursing practice. As the first study to apply Bourdieu's perspective to an understanding of nursing practice, several issues arising from the study merit discussion.

**The Importance of the Field**

Unlike previous studies of nursing pain assessment, which have tended to focus on nurse's knowledge and application of pain assessment knowledge, but have made only passing reference to the setting of nursing practice, this study was
grounded in the belief that, as a social practice, nursing is deeply shaped by the specific field in which it is practiced. While earlier works have noted that the nursing unit and nursing unit culture may impact nursing practice (Foster, 1990; Francke, Lemmens, Abu-Saad, & Grypdonck, 1997; Kim & Sjöström, 2000; Price & Pooler-Lunse, 1996; Wild & Mitchell, 2000), or serve as a barrier to the application of new knowledge in practice (Czurylo, Gattuso, Epsom, & Stark, 1999; Dalton et al., 1998; Francke et al., 1997; Nash et al., 1999; Price & Pooler-Lunse, 1996; Wild & Mitchell, 2000), no studies have specifically viewed nursing practice as social practice and examined the field of practice as a key variable.

In this study, the two fields of practice exhibited both similarities and differences. As nursing units in the same institution, they were governed by the same polices and procedures, and supported by the same nursing administration. They also provided care to similar groups of clients. However, in practice, there were many meaningful differences. Using Bourdieu’s approach, capital differed between the two units. On Unit A, capital came primarily in the form of reward and recognition from physicians. On Unit B, capital came from rewards and recognition from clients and peers. The nature of interaction between nurses with respect to pain assessment practice was different between the two units.

These differences profoundly shaped the way nursing pain assessment was carried out in the two units.
Nursing Pain Assessment Habitus

Nurses in each unit manifested remarkable similar dispositions of the habitus with respect to pain assessment practice. Two elements of pain assessment habitus were common across fields. First, nurses in both fields demonstrated use of the three criteria assessed by the Pain Assessment Inventory (Client's Description, Observable Criteria and Reference Typology) in their assessment practice, although the balance of each differed across units.

The Power of Collective Habitus

The findings of this study highlight the pervasive influence of collective habitus on the practice of the individual nurse. In this study, the practice of the individual nurse was profoundly shaped by the predominant habitus in the field, and this influence was largely unnoticed by the nurses themselves. It seems reasonable to expect that one potential reason that interventions to date designed to improve nursing pain assessment practice have met with limited success is that they fail to account for an understanding of the influence of collective habitus. For instance, an individual nurse, armed with new knowledge regarding pain assessment is less likely to consistently apply this knowledge in practice if it is inconsistent with the collective habitus predominant on the nursing unit.

Critiques of the Theory

Bourdieu's work has received considerable attention, and has generated a considerable body of research in a number of disciplines. The theory is not without its challenges and limitations.
Dreyfus and Rabinow (1999) suggest that by proposing that all human action is geared toward the acquisition and maximization of capital, Bourdieu actually develops an objectivist approach to the study of human action, while at the same time insisting that his work transcend the subjectivist-objectivist duality.

Bourdieu has been criticized for the vagueness of conceptual definitions. Cicourel (1993) suggests that in particular, the concept of habitus would be of greater theoretical use if the concept were further clarified by both empirical study and conceptual refinement.

In the current study, one similar challenge arose regarding the concept of field. Bourdieu is insistent that field is defined by relationships between agents, as opposed to geographical boundaries. Hospital-based nursing practice occurs within geographically defined nursing units. Relationships (transactional relationships that involve the exchange of capital) generally exist within the unit space, although there are also relationships that exist outside of the unit borders. In an attempt to be consistent with Bourdieu’s approach, with respect to nursing pain assessment, this study conceptualized each nursing unit as a field, contained within a larger organizational field.

Similarly, because field is defined by relationships, and because nursing practice occurs over a twenty-four hour day, and with different agents operating at different points in the daily cycle, this study focused on the analysis of each field only during the day shift. For the purposes of this study, the evening and night shifts represent different fields. Further refinement of the concept of field as it
relates specifically to the understanding of nursing practice may be necessary to enhance the applicability of the theory to an examination of nursing practice.

**Challenges in Application of the Theory**

While the use of Bourdieu’s approach serves to illuminate aspects of practice that have previously received little attention in the nursing literature, there were also some challenges presented in its’ use in this study. As described, the first of these has been noted in other critiques of Bourdieu’s work and relates to the vagueness of explication of key concepts and relational statements. While Bourdieu challenges that this lack of concrete definitions is deliberate, and reflects the reality of human practice in a number of settings, it also poses challenges in the interpretation of data.

In this study, one such difficulty relates to an understanding of the application of dispositions of the habitus. Bourdieu suggests that when the agent is in a familiar field, that the habitus operates at a preconscious level. What is poorly described, however, is how the agent makes decisions in practice when the fit with the collective habitus is poor. Other models of decision making may have applicability in this instance. For example, Maureen’s description of her assessment of a client who falls outside the expected trajectory seems consistent with tenets of hypothetico-deductive models of decision-making in practice. Based on initial assessment, this nurse generates a tentative diagnostic hypothesis, and then interprets cues obtained in her ongoing assessment as either supporting or refuting this hypothesis.
However, the predominant form of pain assessment practice on Unit A is not consistent with a hypothetico-deductive approach. In general, the nurses approach the client with a particular perspective well established before any data is collected. Also, the nurses on Unit A collect data from a variety of sources (including data which are irrelevant to pain assessment) and process them through the filter of the nurse’s perspective. What Bourdieu’s theory does not help to illuminate is the process whereby data are evaluated as either having meaning to the assessment of pain, or as being irrelevant. Nursing discourse, in particular, is replete with descriptions of the importance of providing care to the individual client as a whole and conducting assessments that are comprehensive and holistic, that nurses may choose to use all sources of data available to them, even when they are not relevant to the issue at hand. Nurses on Unit A, for instance, see themselves as conducting comprehensive pain assessments, when both the field data and the quantitative data suggest that the assessments are unfocused. It may be that nurses, on this unit at least, are unable to separate focused assessments targeted at understanding a specific aspect of a client’s condition (i.e. pain assessment) from more generalized ongoing assessments of the client as a whole.

Secondly, for nurses in both units the practice of pain assessment and pain management were deeply intertwined. Kim (2000) proposes that practice can be conceptualized as including two phases: deliberation and enactment. Kim also suggests that distinction between these two phases may not be conscious. For the nurses in this study, the process of assessment was so closely tied to action (doing
for the client) that it was impossible to provide a pure description of assessment that did not include intervention.

The concept of intervention also merits discussion. While the nursing literature is replete with descriptions of nonpharmacological intervention for pain, for the nurses in this study, intervention for pain was almost always synonymous with pharmacological intervention. Nurses rarely described the use of nonpharmacological interventions for pain management.

Bourdieu’s theory may have the most applicability for nursing in understanding forms of practice which are routine and consistent with the collective habitus on the nursing unit, but the use of alternative conceptualizations may serve to further our understanding of what occurs when practice is outside of these bounds. Examination of nursing assessment practice that ignores the role of cognition is incomplete.

The final challenge of application of the theory relates to changes in habitus over time. Because habitus operates at a preconscious level, agents in the field are largely unable to describe how habitus is formed or maintained. Nurses in both of the study units could describe that there existed a predominant pattern of nursing pain assessment, but were incapable of describing how this pattern came to exist, or how it was maintained. Using Bourdieu’s perspective, the development of an understanding and assessing changes over time must be done through analysis of the field over time (i.e. must examine structural relationships), and because the field is by its’ nature resistant to change, this process would be
incredibly labor intensive. Perhaps, the use of the Pain Assessment Inventory to measure changes over time might have applicability to this line of research.

**Implications for the Practice Domain**

For nursing practice, it is important to recognize that the character of practice on a unit both shapes and is shaped by the practice of the individual nurse. Changes to the collective habitus do occur, but they occur more slowly and over time. Therefore, it is unlikely that “quick fix” interventions designed as a one time approach to changing practice are less likely to be successful than interventions that recognize the basic stability of practice within the field and which stress change over time. Secondly, interventions designed to improve nurses’ pain assessment practice are less likely to be effective if they do not address the nature of capital within the field. An intervention that asks nurses to practice in ways that are not rewarded, or are sanctioned by either the peer group or others in power are unlikely to promote sustained change. Long term change in practice will require both knowledge of the field of practice as it exists, and may also require changes to the existing capital within the field. This also supports the notion that interventions designed to change nurses pain assessment practice will need to not only consider the impact of context, but also will need to be unit-specific.

**Implications for Research**

This study represents the first attempt to utilize Bourdieu’s theory as a lens through which to assess nursing practice. As such, there are several implications for research. First, the model of nursing pain assessment developed in this study
should be tested in other nursing units. While this model is grounded in earlier work by Sjostrom and others in multiple settings, in it’s current form, it has been developed using only two units. Further refinement of the model could be developed based on similar studies in other nursing units.

Another important question concerns interventions designed to improve nurses’ pain assessment practice, and their ability to sustain changes in practice over time. The findings of this study suggest the importance of developing interventions that are nursing-unit specific, and that address the nature of nursing practice, and nursing interaction in the specific field of practice. One next step might be to develop and test interventions that are specifically targeted at these two units.

It is hoped that further refinement of the PAI will lead to the development of an instrument that will be useful to measure changes in nursing pain assessment practice over time.

Additionally, while the nursing literature suggests that the client’s description of their pain is the single most reliable indicator of pain, no studies have yet examined this belief in a systematic fashion. One potential avenue for further study would be to explore the relationship between different modes of assessment and client outcomes including length of stay, postoperative morbidity, etc.
Implications for Nursing Education

The study also has implications for nursing education. Students can be more adequately prepared for practice as a social phenomenon, and could be prepared to more adequately assess the fit between their own practice, and practice on a unit where they may choose to work. Similarly sites for clinical education might be selected on the basis of collective nursing habitus in order to expose students to desirable models of practice.
APPENDICES
APPENDIX A

Letter of Introduction to Nurses Participating in Instrument Development
Dear Registered Nurse:

As a student in the Doctoral Program in the College of Nursing, University of Rhode Island, I am conducting a study designed to better understand the way nurses assess pain in postoperative patients. Part of this study involves the creation of a survey instrument to measure the kinds of strategies that nurses use to assess pain when they are caring for postoperative patients.

You are being asked to consider participating in the study by completing the enclosed questionnaire that asks you about the specific kinds of things you do when assessing pain in postoperative patients. Completing the questionnaire should take about 20 minutes. If you choose to participate, please return the questionnaire in the enclosed envelope to the box provided on the nursing unit within one week. Your filling out the survey implies your consent to participate in this study.

Participation in the study is strictly voluntary. If you do not wish to participate, simply do not complete the questionnaires. There are no anticipated discomforts or risks to nurses who choose to participate in the study. There are no anticipated direct benefits to nurses for participating in the study. It is hoped that the information gained from the study may help to find ways to share successful strategies for assessing pain in postoperative patients.

If you choose to participate, your responses will be anonymous and confidential. Since the questionnaires are coded only by number, neither I nor anyone else will be able to identify you, or to identify which nurses choose not to participate. The results of the study will be reported in my doctoral dissertation and in various presentations of grouped data. Individual responses will not be reported.

If you have any questions regarding the study, please feel free to contact me at [Redacted]. You may also contact my dissertation advisor, Dr. Hesook Suzie Kim through the College of Nursing, University of Rhode Island.

If you are not satisfied with the way this study is performed, you may discuss your complaints with me or with Dr. Hesook Suzie Kim [Redacted] anonymously, if you choose. In addition, you may contact the office of the Vice Provost for Graduate Studies, Research and Outreach, 70 Lower College Road, Suite 2, University of Rhode Island, Kingston, Rhode Island, telephone: [Redacted].

Thank you for considering this request.
Sincerely,

Laurie M. Lauzon Clabo
Doctoral Candidate, University of Rhode Island
APPENDIX B

THE PAIN ASSESSMENT INVENTORY
**Pain Assessment Inventory**

The following list describes some ways that nurses might assess pain in postoperative patients. Nurses have described that some things are more or less helpful to them when they conduct these assessments. Please rate the importance of each of the following strategies for you as you assess postoperative patients’ pain in your day to day practice. You may find it easier to rate these items if you recall your most recent clinical experiences with postoperative pain management. Rate each strategy from 1 (not important/don’t use it) to 5 (very important/always use it).

When I assess a postoperative patient’s pain:

<table>
<thead>
<tr>
<th></th>
<th>Don’t use it</th>
<th>Rarely use it</th>
<th>Use it sometimes</th>
<th>Use it most times</th>
<th>Always use it</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I observe the patient’s facial expression.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2.</td>
<td>I listen to the patient’s description of his or her pain.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3.</td>
<td>I observe how the patient moves.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4.</td>
<td>I know what to expect from patients who have had different kinds of surgery.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5.</td>
<td>I listen to the patient’s rating of his or her pain.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6.</td>
<td>I ask about support available from patient’s family.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7.</td>
<td>I think about past experiences related to pain management.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8.</td>
<td>I observe the way the patient talks with others.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9.</td>
<td>I review the patient’s intake and output.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10.</td>
<td>I listen to what the patient says about his or her pain.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

PLEASE TURN OVER →
<table>
<thead>
<tr>
<th></th>
<th>Don’t use it</th>
<th>Rarely use it</th>
<th>Use it sometimes</th>
<th>Use it most times</th>
<th>Always use it</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.</td>
<td>I look for moaning or grunting.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12.</td>
<td>I assess the patient’s temperature.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>13.</td>
<td>I listen to the patient’s tone of voice.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>14.</td>
<td>I listen to specific words the patient uses to describe his or her pain.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>15.</td>
<td>I have learned what patients who have this surgery generally experience.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>16.</td>
<td>I listen to the way the patient talks.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>17.</td>
<td>I observe the patient’s body posture/position.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>18.</td>
<td>I think about past experiences, and patients in similar circumstances.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>19.</td>
<td>I observe the patient’s overall demeanor.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>20.</td>
<td>I assess the patient’s skin turgor.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

21. Is there another way that you assess pain in postoperative patients that is not mentioned in the above list? If so, please describe.

22. If you could use only one method to assess pain in postoperative patients, what would it be? Please choose only one of the methods described in items 1 to 20.

#
APPENDIX C

Letter of Introduction to Staff on Participating Units
Description of Research Project

To all staff on Nursing Unit X:

I am a graduate student in the PhD program in the College of Nursing at the University of Rhode Island and am currently working on my doctoral dissertation. My dissertation will describe the ways that nurses assess pain in postoperative patients, and how nurses learn (through education and experience) the strategies that they use to assess pain in postoperative patients. It is hoped that the information gained from this study will be used to help nurses develop the use of effective strategies to assess pain in postoperative patients.

The study will be conducted over a period of nine months. During the first seven to ten weeks I will be observing on the unit in order to gain a sense of familiarity with the unit and the staff. During this time, I may approach you to ask questions about various aspects of postoperative pain assessment, and to get an understanding of unit protocol for caring with such patients. I hope you will also feel free to approach me with any questions you might have.

During the second seven to ten weeks, I will be shadowing a small number of nurses who agree to participate in the study, as they do assessments of postoperative patients. This process will be explained to nurses who participate in a separate letter. I will also be asking small groups of nurses to consider participating in focus group discussions about pain assessment.

At the end of my time on the unit, I will be asking nurses to consider completing a survey checklist that involves answering questions about the specific strategies that they use to assess patients’ pain.

All information gained in the conduct of this study will be used for research purposes only. The findings will be presented in my doctoral dissertation and in various presentations of data. Neither the units that participate in the study, nor individuals who choose to participate in any phase of the study will be identified.

There are no anticipated discomforts or risks to nurses who choose to participate in the study. There are no anticipated direct benefits to nurses for participating in the study. It is hoped that the information gained from the study may help to find ways to share successful strategies for assessing pain in postoperative patients.

If you are not satisfied with the way this study is performed, you may discuss your complaints with me by telephone at [redacted] (home) or with Dr. Hesook Suzie Kim anonymously, if you choose. In addition, you may contact the office of the Vice Provost for Graduate Studies, Research and Outreach, 70 Lower College Road, Suite 2, University of Rhode Island, Kingston, Rhode Island, telephone: [redacted]
APPENDIX D

Consent Form for Registered Nurses Participating in Phase II
College of Nursing
The University of Rhode Island

Agreement to Participate In a Research Study

Committee # ___________________________  Name of Study Volunteer ___________________________

Examining the Role of Social Context in Nurses’ Pain Assessment Practice With Postoperative Clients

You are being asked to take part in a research study. All research studies carried out at XXXXXXX institutions are covered by rules of the Federal government as well as rules of the State and XXXXXXX. Under these rules, the researcher will first explain the study, and then he or she will ask you to participate. You will be asked to sign this agreement which states that the study has been explained, that your questions have been answered, and that you agree to participate.

The researcher will explain the purpose of the study. He or she will explain how the study will be carried out and what you will be expected to do. The researcher will also explain the possible risks and possible benefits of being in the study. You should ask the researcher any questions you have about any of these things before you decide whether you wish to take part in the study. This process is called informed consent.

This form also explains the research study. Please read the form and talk to the researcher about any questions you may have. Then, if you decide to be in the study, please sign and date this form in front of the person who explained the study to you. You will be given a copy of this form to keep.

The specifics of the study are described in the following paragraphs. The researcher, Laurie Lauzon Clabo, a doctoral student in the College of Nursing at the University of Rhode Island, will explain the study to you in detail. If you have questions about the study, at any time, you may address them to the researcher.

1. Nature and Purpose of the Study
The purpose of this study is to learn about the specific things that nurses do to care for people who have had surgery. The goal of the study is to explore the kinds of things that nurses find successful caring for people after surgery, and also to learn about how nurses learned these skills through their experience.

2. **Explanation of Procedures**

You are being asked to participate in one specific phase of the study. Your participation in this phase would involve allowing the researcher to accompany your nurse when he/she provides care for you. The researcher will accompany your nurse, but will not participate in your care. The researcher will take written notes about the things that the nurse does for you. The researcher will not have access to your medical records.

If you have any questions or concerns about the research study, you may contact the researcher, Laurie Lauzon Clabo at [redacted].

3. **Discomforts and Risks**

There are no anticipated discomforts or risks to patients who choose to participate in the study.

4. **Benefits**

There are no anticipated direct benefits to me for participating in the study. It is hoped that the information gained from the study may help to find ways to share successful strategies for assessing pain in postoperative patients.

5. **Alternative Therapies**

This study does not involve any change in your treatment in any way. Patients who choose to participate in the study will receive the same treatment as patients who choose not to participate. No alternative therapies are proposed.

6. **Confidentiality**

The information that the researcher collects will be used for research purposes only, including teaching and publication. Your participation in the study will be confidential. You will not be identified in any presentation of research data.
The notes pertaining to the study will be identified only by code number and no identifying data will be presented. They will be stored in locked file cabinets accessible only to the researcher. The notes will be stored separately from this consent form, which is the only documentation of your participation in this study. After the dissertation is completed, the researcher will retain the notes for possible further use in later studies, and the notes will continue to be safeguarded as described above. Data will be stored for at least three years following completion of the study.

7. **Refusal/Withdrawal**

Your participation in this study is strictly voluntary. There will be no consequences to you for refusal to participate. If you choose to participate in the study, you may withdraw from the study at any time.

8. **Medical Treatment/Payment in Case of Injury**

We do not expect that you will be hurt by taking part in this research study. However, if you are hurt as a result of taking part in this study, XXXXXXX will provide without charge to you, what it feels is fair and proper treatment. XXXXXXX does not however, have any plan or money set aside to pay you (for “pain or suffering”) if you are hurt. Signing this agreement does not lessen or take away any of your lawful rights. For more facts about these terms, please contact XXXX XXXXXXXX in the Office of Research Administration at XXX-XXX.

9. **Rights and Complaints**

If you have any questions regarding the study, you may contact the researcher, Laurie Lauzon Clabo, at either home. You may also contact her dissertation advisor, Dr. Hesook Suzie Kim through the College of Nursing, University of Rhode Island.

If you are not satisfied with the way this study is performed, you may discuss your concerns with Laurie Lauzon Clabo or with Dr. Hesook Suzie Kim, anonymously, if you choose. In addition, you may contact the office of the Vice Provost for Graduate Studies, Research and Outreach, 70 Lower College Road, Suite 2, University of Rhode Island, Kingston, Rhode Island, telephone: 

If you have any complaints about your taking part in this study, or would like more facts about the rules for research studies, or the rights of people
who take part in research studies, you may contact Kathy Xxxxxxxx, in the Xxxxxxx Office of Research Administration, at xxx-xxxx.

I HAVE READ THE ABOVE DESCRIPTION OF THIS STUDY. ALL OF MY QUESTIONS HAVE BEEN SATISFACTORILY ANSWERED, AND I WANT TO TAKE PART IN THIS RESEARCH STUDY.

Signature of study volunteer/authorized representative* ___________________________ Date ___________________________

I WAS PRESENT DURING THE CONSENT PROCESS AND SIGNING OF THIS AGREEMENT ABOVE BY THE STUDY VOLUNTEER OR AUTHORIZED REPRESENTATIVE

Signature of witness (required if consent is presented orally or at the request of the IRB) ___________________________ Date ___________________________

I ASSURE THAT I HAVE FULLY EXPLAINED TO THE ABOVE STUDY VOLUNTEER/AUTHORIZED REPRESENTATIVE, THE NATURE AND PURPOSE, PROCEDURES AND THE POSSIBLE RISK AND POTENTIAL BENEFITS OF THIS RESEARCH STUDY.

Signature of researcher or designate ___________________________ Date ___________________________

Consent form copy: [ ] study volunteer [ ] medical record [ ] researcher [ ] other (specify)

*If signed by agent other than study volunteer, please explain below.
APPENDIX E

Consent Form for Clients
College of Nursing
The University of Rhode Island

Agreement to Participate In a Research Study

Committee # ___________________________ Name of Study Volunteer ___________________________

Examing the Role of Social Context in Nurses' Pain Assessment Practice With Postoperative Clients

You are being asked to take part in a research study. All research studies carried out at XXXXXXXX institutions are covered by rules of the Federal government as well as rules of the State and XXXXXXXX. Under these rules, the researcher will first explain the study, and then he or she will ask you to participate. You will be asked to sign this agreement which states that the study has been explained, that your questions have been answered, and that you agree to participate.

The researcher will explain the purpose of the study. He or she will explain how the study will be carried out and what you will be expected to do. The researcher will also explain the possible risks and possible benefits of being in the study. You should ask the researcher any questions you have about any of these things before you decide whether you wish to take part in the study. This process is called informed consent.

This form also explains the research study. Please read the form and talk to the researcher about any questions you may have. Then, if you decide to be in the study, please sign and date this form in front of the person who explained the study to you. You will be given a copy of this form to keep.

The specifics of the study are described in the following paragraphs. The researcher, Laurie Lauzon Clabo, a doctoral student in the College of Nursing at the University of Rhode Island, will explain the study to you in detail. If you have questions about the study, at any time, you may address them to the researcher.
1. **Nature and Purpose of the Study**

The purpose of this study is to learn about the specific things that nurses do to assess pain in postoperative patients. The goal of the study is to explore the specific strategies that nurses find successful in assessing pain in postoperative patients. The study will also explore the ways that nurses learn to assess pain in postoperative patients and the role that experience plays in teaching nurses ways to assess pain in these patients. The study will examine the ways that nurses in different postoperative units assess pain, and explore whether and/or how nurses in different units do things differently.

2. **Explanation of Procedures**

You are being asked to participate in one specific phase of the study. Your participation in this phase would involve allowing the researcher to accompany you when you conduct pain assessments on postoperative patients over the course of five or six shifts. The researcher will accompany you to assess patients, but will not participate in the assessment. Shortly after, the researcher will conduct an interview (40 to 60 minutes) to ask you questions about the strategies you used to conduct the assessment, including asking what you saw, heard, felt or knew in order to help you determine what the patient’s pain was like. The researcher will also ask questions about how you learned to assess pain in these types of patients and what your experience has taught you about pain assessment. The interview will be audiotaped and transcribed. The researcher will take written notes throughout your discussion.

If you have any questions or concerns about the research study, you may contact the researcher, Laurie Lauzon Clabo at [Contact Information].

3. **Discomforts and Risks**

There are no anticipated discomforts or risks to nurses who choose to participate in the study.

4. **Benefits**

There are no anticipated direct benefits to me for participating in the study. It is hoped that the information gained from the study may help to find ways to share successful strategies for assessing pain in postoperative patients.
5. **Alternative Therapies**

This study does not involve any change in treatment. No alternative therapies are proposed.

6. **Confidentiality**

The information that you provide will be used for research purposes only, including teaching and publication. Your participation in the study will be confidential. You will not be identified in any presentation of research data.

The audiotapes, transcriptions and notes pertaining to the study will be identified only by code number and no identifying data will be presented. They will be stored in locked file cabinets accessible only to the researcher. The notes will be stored separately from this consent form, which is the only documentation of my participation in this study. After the dissertation is completed, the researcher will retain the notes for possible further use in later studies, and the notes will continue to be safeguarded as described above. Data will be stored for at least three years following completion of the study.

7. **Refusal/Withdrawal**

Your participation in this study is strictly voluntary. There will be no consequences to you for refusal to participate. If you choose to participate in the study, you may withdraw from the study at any time.

8. **Medical Treatment/Payment in Case of Injury**

We do not expect that you will be hurt by taking part in this research study. However, if you are hurt as a result of taking part in this study, XXXXXXXX will provide without charge to you, what it feels is fair and proper treatment. XXXXXXXX does not however, have any plan or money set aside to pay you (for “pain or suffering”) if you are hurt. Signing this agreement does not lessen or take away any of your lawful rights. For more facts about these terms, please contact Xxxxx Xxxxxxxx in the Office of Research Administration at xxx-xxxx.

9. **Rights and Complaints**

If you have any questions regarding the study, you may contact the researcher, Laurie Lauzon Clabo, at either [phone number] (home). You may also contact her dissertation advisor, Dr. Hesook Suzie...
Kim through the College of Nursing, University of Rhode Island.

If you are not satisfied with the way this study is performed, you may discuss your concerns with Laurie Lauzon Clabo or with Dr. Hesook Suzie Kim, anonymously, if you choose. In addition, you may contact the office of the Vice Provost for Graduate Studies, Research and Outreach, 70 Lower College Road, Suite 2, University of Rhode Island, Kingston, Rhode Island, telephone: [redacted].

If you have any complaints about your taking part in this study, or would like more facts about the rules for research studies, or the rights of people who take part in research studies, you may contact Kathy [redacted], in the XXXXXXXX Office of Research Administration, at xxx-xxxx.

I HAVE READ THE ABOVE DESCRIPTION OF THIS STUDY. ALL OF MY QUESTIONS HAVE BEEN SATISFACTORILY ANSWERED, AND I WANT TO TAKE PART IN THIS RESEARCH STUDY.

__________________________________________  __________________________
Signature of study volunteer/authorized representative* Date

I WAS PRESENT DURING THE CONSENT PROCESS AND SIGNING OF THIS AGREEMENT ABOVE BY THE STUDY VOLUNTEER OR AUTHORIZED REPRESENTATIVE

__________________________________________  __________________________
Signature of witness (required if consent is presented orally or at the request of the IRB) Date
I ASSURE THAT I HAVE FULLY EXPLAINED TO THE ABOVE STUDY VOLUNTEER/AUTHORIZED REPRESENTATIVE, THE NATURE AND PURPOSE, PROCEDURES AND THE POSSIBLE RISK AND POTENTIAL BENEFITS OF THIS RESEARCH STUDY.

__________________________________________________________________________  _______________________
Signature of researcher or designate                                            Date

Consent form copy: □ study volunteer  □ medical record  □ researcher  □ other(specify)

*If signed by agent other than study volunteer, please explain below.
APPENDIX F

Consent Form for Nurses Participating in Focus Groups
College of Nursing  
The University of Rhode Island  

Agreement to Participate In a Research Study  

Committee #  
Name of Study Volunteer  

*Examing the Role of Social Context in Nurses' Pain Assessment Practice With Postoperative Clients*  

You are being asked to take part in a research study. All research studies carried out at XXXXXXX institutions are covered by rules of the Federal government as well as rules of the State and XXXXXXX. Under these rules, the researcher will first explain the study, and then he or she will ask you to participate. You will be asked to sign this agreement which states that the study has been explained, that your questions have been answered, and that you agree to participate.

The researcher will explain the purpose of the study. He or she will explain how the study will be carried out and what you will be expected to do. The researcher will also explain the possible risks and possible benefits of being in the study. You should ask the researcher any questions you have about any of these things before you decide whether you wish to take part in the study. This process is called informed consent.

This form also explains the research study. Please read the form and talk to the researcher about any questions you may have. Then, if you decide to be in the study, please sign and date this form in front of the person who explained the study to you. You will be given a copy of this form to keep.

The specifics of the study are described in the following paragraphs. The researcher, Laurie Lauzon Clabo, a doctoral student in the College of Nursing at the University of Rhode Island, will explain the study to you in detail. If you have questions about the study, at any time, you may address them to the researcher.
1. **Nature and Purpose of the Study**

   The purpose of this study is to learn about the specific things that nurses do to care for people who have had surgery. The goal of the study is to explore the kinds of things that nurses find successful caring for people after surgery, and also to learn about how nurses learned these skills through their experience.

2. **Explanation of Procedures**

   You are being asked to participate in one specific phase of the study. Your participation in this phase would involve participating in a focus group discussion with the researcher and three or four other nurses working on this unit. It is anticipated that this discussion will last approximately one hour. The purpose of the discussion is to talk about the strategies that nurses on this unit use to assess pain in postoperative patients. We will talk about how nurses learn to assess pain in postoperative patients, and the role of experience in teaching nurses about assessing pain. The discussion will be audiotaped and transcribed. The researcher will also take written notes throughout the discussion.

   If you have any questions or concerns about the research study, you may contact the researcher, Laurie Lauzon Clabo at [contact information].

3. **Discomforts and Risks**

   There are no anticipated discomforts or risks to patients who choose to participate in the study.

4. **Benefits**

   There are no anticipated direct benefits to me for participating in the study. It is hoped that the information gained from the study may help to find ways to share successful strategies for assessing pain in postoperative patients.

5. **Alternative Therapies**

   This study does not involve any change in your treatment in any way. Patients who choose to participate in the study will receive the same treatment as patients who choose not to participate. No alternative therapies are proposed.
6. **Confidentiality**

The information that the researcher collects will be used for research purposes only, including teaching and publication. Your participation in the study will be confidential. You will not be identified in any presentation of research data. Nurses participating in focus group discussions are encouraged to maintain strict confidentiality. However, confidentiality of your identity or information discussed in group sessions cannot be guaranteed by the researcher.

The notes pertaining to the study will be identified only by code number and no identifying data will be presented. They will be stored in locked file cabinets accessible only to the researcher. The notes will be stored separately from this consent form, which is the only documentation of your participation in this study. After the dissertation is completed, the researcher will retain the notes for possible further use in later studies, and the notes will continue to be safeguarded as described above. Data will be stored for at least three years following completion of the study.

7. **Refusal/Withdrawal**

Your participation in this study is strictly voluntary. There will be no consequences to you for refusal to participate. If you choose to participate in the study, you may withdraw from the study at any time.

8. **Medical Treatment/Payment in Case of Injury**

We do not expect that you will be hurt by taking part in this research study. However, if you are hurt as a result of taking part in this study, XXXXXXXX will provide without charge to you, what it feels is fair and proper treatment. XXXXXXXX does not however, have any plan or money set aside to pay you (for “pain or suffering”) if you are hurt. Signing this agreement does not lessen or take away any of your lawful rights. For more facts about these terms, please contact XXXXX XXXXXXXX in the Office of Research Administration at XXX-XXXX.

9. **Rights and Complaints**

If you have any questions regarding the study, you may contact the researcher, Laurie Lauzon Clabo, at either [email address] (home). You may also contact her dissertation advisor, Dr. Hesook Suzie Kim through the College of Nursing, University of Rhode Island [email address].
If you are not satisfied with the way this study is performed, you may discuss your concerns with Laurie Lauzon Clabo or with Dr. Hesook Suzie Kim, anonymously, if you choose. In addition, you may contact the office of the Vice Provost for Graduate Studies, Research and Outreach, 70 Lower College Road, Suite 2, University of Rhode Island, Kingston, Rhode Island, telephone: [redacted]

If you have any complaints about your taking part in this study, or would like more facts about the rules for research studies, or the rights of people who take part in research studies, you may contact Xxxxx Xxxxxxxx, in the Xxxxxxxx Office of Research Administration, at xxx-xxxx.

I HAVE READ THE ABOVE DESCRIPTION OF THIS STUDY, ALL OF MY QUESTIONS HAVE BEEN SATISFACTORILY ANSWERED, AND I WANT TO TAKE PART IN THIS RESEARCH STUDY.

__________________________________________
Signature of study volunteer/authorized representative* ________________ Date

I WAS PRESENT DURING THE CONSENT PROCESS AND SIGNING OF THIS AGREEMENT ABOVE BY THE STUDY VOLUNTEER OR AUTHORIZED REPRESENTATIVE

__________________________________________
Signature of witness (required if consent is presented orally or at the request of the IRB) ________________ Date
I ASSURE THAT I HAVE FULLY EXPLAINED TO THE ABOVE
STUDY VOLUNTEER/AUTHORIZED REPRESENTATIVE, THE
NATURE AND PURPOSE, PROCEDURES AND THE POSSIBLE RISK
AND POTENTIAL BENEFITS OF THIS RESEARCH STUDY.

______________________________  _______________________
Signature of researcher or designate          Date

Consent form copy: □ study volunteer □ medical record □ researcher □
other(specify)

*If signed by agent other than study volunteer, please explain below.
APPENDIX G

Letter of Explanation for Nurses Participating in Phase III
Dear Registered Nurse:

As a student in the Doctoral Program in the College of Nursing, University of Rhode Island, I am conducting a study designed to better understand the way nurses assess pain in postoperative patients.

You are being asked to consider participating in the study by completing the enclosed questionnaire that asks you about the specific kinds of things you do when assessing pain in postoperative patients. Completing the questionnaire should take about 20 minutes. If you choose to participate, please return the questionnaire in the enclosed envelope to the box provided on the nursing unit within one week. Your filling out the survey implies your consent to participate in this study.

Participation in the study is strictly voluntary. If you do not wish to participate, simply do not complete the questionnaires. There are no anticipated discomforts or risks to nurses who choose to participate in the study. There are no anticipated direct benefits to nurses for participating in the study. It is hoped that the information gained from the study may help to find ways to share successful strategies for assessing pain in postoperative patients.

If you choose to participate, your responses will be anonymous and confidential. Since the questionnaires are coded only by number, neither I nor anyone else will be able to identify you, or to identify which nurses choose not to participate. The results of the study will be reported in my doctoral dissertation and in various presentations of grouped data. Individual responses will not be reported.

If you have any questions regarding the study, please feel free to contact me at [Redacted]. You may also contact my dissertation advisor, Dr. Hesook Suzie Kim through the College of Nursing, University of Rhode Island.
If you are not satisfied with the way this study is performed, you may discuss your complaints with me or with Dr. Hesook Suzie Kim anonymously, if you choose. In addition, you may contact the office of the Vice Provost for Graduate Studies, Research and Outreach, 70 Lower College Road, Suite 2, University of Rhode Island, Kingston, Rhode Island, telephone:

Sincerely,

Laurie M. Lauzon Clabo
Doctoral Candidate, University of Rhode Island
APPENDIX H

Interview Guide for Individual Nurses
Interview Guide for Individual Nurses

- What kinds of things did you do to help you were assessing patient X?
  - Probes:
    - What sorts of things did you see?
    - What sorts of things did you look for?
    - What sorts of things did you hear?
    - Were there specific things you noticed in terms of verbalizations, movement, positioning, anxiety, restlessness, activities, mood, ADL’s?

- What sorts of factors helped you to assess this patient’s pain?
  - Probes:
    - What signs/symptoms were most important to you?
    - What other signs/symptoms did you notice?
    - How did these help you to understand the patient’s pain?

- How did you learn to assess people like patient X?
  - Probes:
    - Role of education?
    - Other nurses? Who? Where?
    - Others health care providers?
    - Lessons from patients?
    - Lessons from personal/family experience?

- Is patient X typical or different from other patients who have had this surgical procedure?
  - Probes:
    - How similar or different?
    - Similarities or differences based on age? Diagnosis? Concurrent illnesses?

- Was this patient’s pain in any way different from what you would expect? How?

- How do you think other nurses approach the assessment of pain in patients like patient X?
APPENDIX I

Guide for Focus Group Interviews
Guide for Focus Group Interviews

- What are the protocols for pain assessment on this unit?
- How do you decide how often to conduct pain assessments on patients?
- What kinds of things do nurses on this unit do when assessing pain in postoperative patients?
- How do new nurses learn to assess pain in postoperative patients?
- What would you do if you thought a nurse’s assessment of a patient was incorrect?
- What would you do if you thought a nurse had special skill in assessing pain in postoperative patients?
- How do you know if your assessments of pain are accurate?
- What are the rewards for doing pain assessments on this unit?
APPENDIX J

Acute Pain Management In Adults: Operative Procedures

AHCPR Publication No. 92-0019:February 1993
Attention clinicians:

This Quick Reference Guide contains excerpts from the Clinical Practice Guideline for Acute Pain Management: Operative or Medical Procedures and Trauma, which was developed by an interdisciplinary, non-Federal panel made up of health care practitioners, an ethicist, and a consumer. Panel members were: Daniel B. Carr, MD, (co-chair); Ada K. Jacox, RN, PhD, FAAN (co-chair); C. Richard Chapman, PhD; Betty Farrell, RN, PhD, FAAN; Howard L. Fields, MD, PhD; George Heidrich III, RN, MA; Nancy O. Hester, RN, PhALice: C. Stratton Hill, MD; Arthur G. Lipnaii, PharmD; Charles L. McGarvey, MS; Christine Miaskowski, RN, PhD; David Stevenson Mulder, MD; Richard Payne, MD; Neil Schechter, MAlice: Barbara S. Shapiro, MD; Robert Smith, PhL; Carole V. Tsou, MD; and Loretta Vecchiarrelli.


Users should not rely on these excerpts alone but should refer to the complete Clinical Practice Guideline for more detailed analysis and discussion of available research, critical evaluation of the assumptions and knowledge of the field, considerations for patients with special needs (e.g., intercurrent illness or substance abuse), and references. As stated in the Clinical Practice Guideline, decisions to adopt any particular recommendation must be made by the practitioner in light of available resources and circumstances presented by individual patients.

For further information or to receive additional copies of guideline documents, call: 800-424-9967.
or you may write to the:

Center for Research Dissemination and Liaison  
AHCPR Publications Clearinghouse  
P.O. Box 8547  
Silver Spring, MD 20907

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Introduction

The obligation to manage pain and relieve a patient's suffering is an important part of a health professional's commitment. The importance of pain management is further increased when benefits for the patient are realized—earlier mobilization, shortened hospital stay and reduced costs. Yet clinical surveys continue to show that routine orders for intramuscular injections of opioid "as needed" result in unrelieved pain due to ineffective treatment in roughly half of postoperative patients. Recognition of the inadequacy of traditional pain management has prompted recent corrective efforts from a variety of health care disciplines including surgery, anesthesiology, nursing, and pain management groups. The challenge for clinicians is to balance pain control with concern for patient safety and side effects of pain treatments. This Quick Reference Guide is intended to assist clinicians with these decisions.

Patients vary greatly in their medical conditions and responses to surgery, responses to pain and interventions, and personal preferences. Therefore, rigid prescriptions for the management of postoperative pain are inappropriate. Several alternative approaches, appropriately and attentively implemented, prevent or relieve pain. This Quick Reference Guide contains excerpts from the Clinical Practice Guideline for Acute Pain Management: Operative or Medical Procedures and Trauma and addresses the assessment and management of postoperative pain in adults. The excerpts contained in this Quick Reference Guide provide clinicians with a practical and flexible approach to acute pain assessment and management. However, users should not rely only these excerpts alone but should refer the complete Clinical Practice Guideline for a more detailed analysis and discussion of
the available research, critical evaluation of tile assumptions and knowledge of the field, considerations for patients with special needs (e.g. intercurrent medical illness substance abuse), and references.

Effective Management of Postoperative Pain

Requirements

- Pain intensity and relief must be assessed and reassessed at regular intervals.
- Patient preferences must be respected when determining methods to be used for pain management.
- Each institution must develop an organized program to evaluate the effectiveness of pain assessment and management. Without such a program, staff efforts to treat pain may become sporadic and ineffectual.

Principles

- Successful assessment and control of pain depends, in part, on establishing a positive relationship between health care professionals and patients. Patients should be informed that pain relief is an important part of their health care, that information about options to control pain is available to them, and that they are welcome to discuss their concerns and preferences with the health care team.
- Unrelieved pain has negative physical and psychological consequences. Aggressive pain prevention and control that occurs before, during, and after surgery can yield both short- and long-term benefits.
- It is not practical or desirable to eliminate all postoperative pain, but techniques now available make pain reduction to acceptable levels a realistic goal.
- Prevention is better than treatment. Pain that is established and severe is difficult to control.

Pain Assessment and Reassessment

Principles

- Patients who may have difficulty communicating their pain require particular attention. This includes patients who are cognitively impaired, psychotic or severely emotionally disturbed, children and the elderly, patients who do not speak English, and patients whose level of education or cultural background differs significantly from that of their health care team.
- Unexpected intense pain, particularly if sudden or associated with altered vital signs such as hypotension, tachycardia, or fever, should be
immediately evaluated, and new diagnoses such as wound dehiscence, infection, or deep venous thrombosis considered.

- Family members should be involved when appropriate.

Pain Assessment Tools

- The single most reliable indicator of the existence and intensity of pain—and any resultant distress—is the patient's self-report.
- Self-report measurement scales include numerical or adjective ratings and visual analog scales (see Table 1 for examples).
- Tools should be reliable, valid, and easy for the patient and the nurse or doctor to use. These tools may be used by showing a diagram to the patient and asking the patient to indicate the appropriate rating. The tools may also be used by simply asking the patient for a verbal response (e.g. "On a scale of 0 to 10 with 0 as no pain and 10 as the worst pain possible, how would you rate your pain?").
- Tools must be appropriate for the patient's developmental, physical, emotional, and cognitive status.

Preoperative Preparation

- Discuss the patient's previous experiences with pain and beliefs about and preferences for pain assessment and management.
- Give the patient information about pain management therapies that are available and the rationale underlying their use.
- Develop with the patient a plan for pain assessment and management.
- Select a pain assessment tool, and teach the patient to use it. Determine the level of pain above which adjustment of analgesia or other interventions will be considered.
- Provide the patient with education and information about pain control, including training in nonpharmacologic options such as relaxation (see Table 2 for a sample relaxation exercise).
- Inform patients that it is easier to prevent pain than to chase and reduce it once it has become established and that communication of unrelieved pain is essential to its relief. Emphasize the importance of a factual report of pain, avoiding stoicism or exaggeration.

Postoperative Assessment

- Assess the patient's perceptions, along with behavioral and physiologic responses. Remember that observations of behavior and vital signs should not be used instead of a self-report unless the patient is unable to communicate.
- Assess and reassess pain frequently during the immediate postoperative period. Determine the frequency of assessment based on the operation performed and the severity of the pain. For example, pain should be assessed every 2 hours during the first postoperative day after major surgery.
- Increase the frequency of assessment and reassessment if the pain is poorly controlled or if interventions are changing.
- Record the pain intensity and response to intervention in an easily visible and accessible place, such as a bedside flow sheet.
- Revise the management plan if the pain is poorly controlled.
- Review with the patient before discharge the interventions used and their efficacy and provide specific discharge instructions regarding pain and its management.

Management Options

One or more of these approaches may be used:

- **Cognitive-behavioral interventions** such as relaxation, distraction, and imagery. These methods may reduce pain and anxiety and control mild pain, but they do not substitute for pharmacologic management of moderate to severe pain.
- **Systemic administration of opioids** and/or nonsteroidal antiinflammatory drugs (NSAIDs), including acetaminophen.
- **Patient-controlled analgesia (PCA)** usually denotes selfmedication with intravenous opioids, but may include oral or other routes of administration. PCA offers patients a sense of control over their pain and is preferred by most patients to intermittent injections.
- **Spinal analgesia**, usually with an epidural opioid and/or local anesthetic injected intermittently or infused continuously.
- **Intermittent or continuous local neural blockade**, such as intercostal nerve blockade or infusion of local anesthetic through an interpleural catheter.
- **Physical agents** such as massage or application of heat or cold.
- **Transcutaneous electrical nerve stimulation (TENS).**

**Note:** The use of spinal analgesia or neural blockade or the infusion of local anesthetic through interpleural catheters require special expertise and well-defined institutional protocols and procedures for accountability. The administration of regional analgesia is best limited to specially trained and knowledgeable staff, typically under the direction of a acute or postoperative pain treatment service.
Pharmacologic Management

- Pharmacologic management of mild to moderate postoperative pain should begin, unless there is a contraindication, with an NSAID. However, moderately severe to severe pain should normally be treated initially with an opioid analgesic, with or without an NSAID.

NSAIDs

- Even when insufficient alone to control pain, NSAIDS, including acetaminophen, have significant opioid dose-sparing effects on postoperative pain and hence can be useful in reducing opioid side effects (see Table 4 for information on prescribing NSAIDs).
- If the patient cannot tolerate oral medication, alternative routes such as rectal administration can be used. At present, one NSAID (ketorolac) is approved by the Food and Drug Administration for parenteral use.
- NSAIDs must be used with care in patients with thromboctopenia or coagulopathies and in patients who are at risk for bleeding or gastric ulceration. However, acetaminophen does not affect platelet function, and some evidence exists that two salicylates (salsalate and choline magnesium trisalicylate) do not profoundly affect platelet aggregation.

Opioid Analgesics

- Opioid analgesics are the cornerstone for management of moderate to severe acute pain. Effective use of these agents facilitates postoperative activities such as coughing, deep breathing exercises, ambulation, and physical therapy.
- When pain cannot be adequately controlled despite increasing the opioid dose, a prompt search for residual operative pathology is indicated, and other diagnoses such as neuropathic pain should be considered.
- Opioid tolerance and physiologic dependence are unusual in short term postoperative use in opioid-naive patients. Likewise, psychologic dependence and addiction are extremely unlikely to develop after the use of opioids for acute pain.

Choice of Opioid Agent

- Morphine is the standard agent for opioid therapy. If morphine cannot be used because of an unusual reaction or allergy, another opioid such as hydromorphone can be substituted.
- Meperidine should be reserved for very brief courses in patients who have demonstrated allergy or intolerance to other opioids such as morphine and hydromorphone. Meperidine is contraindicated in patients with impaired
renal function or those receiving antidepressants that are monoamine oxidase (MAO) inhibitors. Normeperidine is a toxic metabolite of meperidine, and is excreted through the kidney. Normeperidine is a cerebral irritant, and accumulation can cause effects ranging from dysphoria and irritable mood to seizures.

**Dosage of Opioid Analgesics**

- Patients vary greatly in their analgesic dose requirements and responses to opioid analgesics. The recommended starting doses presented in Table 5 may be inadequate. Subsequent opioid doses must be titrated to increase the amount of analgesia and reduce side effects.
- Relative potency estimates provide a rational basis for selecting the appropriate starting dose, for changing the route of administration (e.g., from parenteral to oral), or for changing from one opioid to another. Equianalgesic doses for opioids are listed in Table 5.
- Patients who have been receiving opioid analgesics before surgery may require higher starting and maintenance doses post-operatively.

**Dosage Schedule**

- Opioid administration relying on patients' or families' demands for analgesic prn, or "as needed," produces delays in administration and intervals of inadequate pain control.
- Analgesics should be administered initially on a regular time schedule. For example, if the patient is likely to have pain requiring opioid analgesics for 48 hours after surgery, morphine might be ordered every 4 hours around-the-clock (not prn) for 36 hours. Opioid administration is contraindicated when respiratory depression is present (less than 10 breaths per minute).
- Once the duration of analgesic action is determined, the dosage frequency should be adjusted to prevent pain from recurring.
- Orders may be written so that a patient may refuse an analgesic if not in pain or forego it if asleep. However, since a steady-state blood level is required for the drug to be continuously effective, interruption of an around-the-clock dosage schedule (e.g., during sleep) may cause a resurgence of pain as blood levels of the analgesic decline.
- Late in the postoperative course, it may be acceptable to give opioid analgesics prn. Switching to prn dosing later in the postoperative course provides pain relief while reducing the risk of adverse effects as the patient's analgesic dose requirement diminishes.
- Clinicians should assess patients at regular intervals to determine the efficacy of the intervention, the presence of side effects, the need for adjustments of dosage and/or interval, or the need for supplemental doses for breakthrough pain.
Route

- Intravenous administration is the parenteral route of choice after major surgery. This route is suitable for bolus administration and continuous infusion (including PCA).
- Repeated intramuscular injections can themselves cause pain and trauma and may deter patients from requesting pain medication. Rectal and sublingual administration are alternatives to intramuscular or subcutaneous routes when intravenous access is problematic. All routes other than intravenous require a lag time for absorption into the circulation.
- Oral administration is convenient and inexpensive. It is appropriate as soon as the patient can tolerate oral intake and is the mainstay of pain management in the ambulatory surgical population.

Nonpharmacologic Management

- Patient teaching should include procedural and sensory information; instruction to decrease treatment and activity-related pain (e.g., pain caused by deep breathing, coughing) and information about the use of relaxation.
- Cognitive-behavioral (e.g., relaxation, distraction, imagery) and physical interventions (e.g., heat, cold, massage) are intended to supplement, not replace, pharmacologic interventions.
- Cognitive/behavioral interventions include a variety of methods that help patients understand more about their pain and take an active role in pain assessment and management.
- Simple relaxation strategies can be effective in helping to manage pain. Basic approaches (see Table 2 for an example) require only a few minutes to teach and can reduce pain and anxiety. Patients benefit from periodic reinforcement and coaching in the use of relaxation techniques.
- Commonly used physical agents include applications of heat and cold, massage, movement, and rest or immobilization. Applications of heat and cold alter the pain threshold, reduce muscle spasm, and decrease local swelling.
- Transcutaneous electrical nerve stimulation (TENS) may be effective in reducing pain and improving physical function.

Special considerations for Elderly Persons

The Clinical Practice Guideline contains a more complete discussion of the special considerations for pain management in the elderly. A summary is provided here.

- Elderly people often suffer multiple chronic, painful illnesses and take multiple medications. They are at greater risk for drug-drug and drug-disease interactions.
• Pain assessment presents unique problems in the elderly, as these patients may exhibit physiologic, psychologic, and cultural changes associated with aging.

• Misunderstanding of the relationship between aging and pain is common in the management of elderly patients. Many health care providers and patients alike mistakenly consider pain to be a normal part of aging. Elderly patients sometimes believe that pain cannot be relieved and are stoic in reporting their pain. The frail and oldest-old (>85 years) are at particular risk for undertreatment of pain.

• Aging need not alter pain thresholds or tolerance. The similarities of pain experience between elderly and younger patients are far more common than are the differences.

• Cognitive impairment, delirium, and dementia are serious barriers to assessing pain in the elderly. Sensory problems such as visual and hearing changes may also interfere with the use of some pain assessment scales. However, as with other patients, the clinician should be able to obtain an accurate self-report of pain from most patients.

• When verbal report is not possible, clinicians should observe for behavioral cues to pain such as restlessness or agitation. The absence of pain behaviors does not negate the presence of pain.

• NSAIDs can be used safely in elderly persons, but their use requires vigilance for side effects, especially gastric and renal toxicity.

• Opioids are safe and effective when used appropriately in elderly patients. Elderly people are more sensitive to analgesic effects of opiate drugs. They experience higher peak effect and longer duration of pain relief.

Institutional Responsibility for Pain Management

The institutional process of acute pain management begins with the affirmation that patients should have access to the best level of pain relief that may safely be provided. (See Table 3 for a summary of the scientific evidence for interventions to manage pain in adults.) Each institution should develop the resources necessary to provide the best and most modern pain relief appropriate to its patients and should designate who and/or which departments are responsible for the required activities.

Optimal application of pain control methods depends on cooperation among different members of the health care team throughout the patient's course of treatment. To ensure that this process occurs effectively, formal means must be developed and used within each institution to assess pain management practices and to obtain patient feedback to gauge the adequacy of pain control.

The institution's quality assurance procedures should be used periodically to assure that the following pain management practices are being carried out:
- Patients are informed that effective pain relief is an important part of their treatment, that communication of unrelieved pain is essential, and that health professionals will respond quickly to their reports of pain. They are also told that a total absence of pain is often not a realistic or even a desirable goal.
- Clear documentation of pain assessment and management is provided.
- There are institution-defined levels for pain intensity and relief that elicit review of current pain therapy, documentation of the proposed modifications in treatment, and subsequent review of their efficacy.
- Each clinical unit periodically assesses a randomly selected sample of patients who have had surgery within 72 hours to determine their current pain intensity, the worst pain intensity in the first 24 hours, the degree of relief obtained from pain management interventions, satisfaction with relief, and satisfaction with the staff's responsiveness.
BIBLIOGRAPHY


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