Patients’ Decision-Making Strategies for Managing Postoperative Pain

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Abstract: Despite technological advances, many postoperative patients continue to suffer unrelied pain. The aim of this study was to identify the strategies used by postoperative patients to bring about pain management decisions. A single-group noncomparative study design was chosen using observations as the means of examining pain activities in 2 surgical units of a metropolitan teaching hospital in Melbourne, Australia. A total of 52 nurses and 312 patients participated in the study, and 316 pain activities were observed. The most common strategy used was patients acting as a passive recipient for pain relief (60%), whereas problem solving (23%) and active negotiation (17%) were less commonly used. Patients in this study were admitted for surgical treatment of a particular condition, and their subsequent pain was specifically related to this acute event. Therefore, the lack of familiarity of the situation and the severity of pain experienced may have encouraged passivity. Patients may have also felt uncertain about how to approach the pain decision, preferring to defer to nurses. Because increased pain levels can be associated with fear, patients could have been unwilling to speak with nurses to discuss their need for pain relief.

Perspective: This paper shows that patient decision making for postoperative pain relief largely involves the use of passive requests, compared with problem solving and active negotiation. Effective communication must be supported between health professionals and patients if shared understandings about treatment options are to become a reality.

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Key words: Pain management, postoperative context, observation, patient strategy, decision making, nursing.

Postoperative pain management presents a major challenge for health professionals for many reasons. Patients are given a vast array of anesthetics during the perioperative period that provide analgesia, sleep, and muscle relaxation. Adverse effects arising from anesthetic use, including nausea, vomiting, and hemodynamic imbalances, can decrease the effectiveness of pain-relieving agents administered in the postoperative period. Patients undergoing surgical procedures may also have comorbid conditions such as hypertension, ischemic heart disease, renal dysfunction, obstructive pulmonary disease, and obesity. Such conditions can lead to postoperative complications if analgesia is not carefully tailored. It is therefore important to choose an effective analgesic regimen, with minimal side effects, to allow timely mobility, optimal functional recovery, and a decreased incidence of postoperative complications.

Although the literature is replete with prescriptive models of how patients should make decisions, no studies were identified that specifically examined patient strategies for making decisions about managing their pain in actual practice. Instead, patients’ perspectives on pain management have mainly been addressed with descriptions of their experience, their perceived satisfaction with care activities, and their attitudes concerning the pain experience.

Common postoperative experiences relating to pain management include patients’ refusal to accept analgesia, patients behaving passively about asking for analgesia, and patients believing they have to tolerate...
pains. Patients may not disclose pain to clinicians because they are perceived to be too busy. There is also a tendency for patients not to actively communicate with clinicians following operations about how they want their pain to be treated. Satisfaction with pain management after surgery occurs when patients are included as an informed partner in discussions about analgesia options, when pain is relieved effectively even though some degree of discomfort is anticipated, and when clinicians show concern about how much pain patients are experiencing. Misinformed patient attitudes also pervade, including the belief that pain is necessary for recovery and that pain occurs as a result of patients’ own wrongdoing.

The observational method can be particularly effective in delineating patient strategies for pain management by examining complex contextual issues that influence clinical activity in actual practice. Contextual issues may include the nurses’ abilities to encourage patient involvement, the availability of health professionals with an expert understanding of analgesic needs, and the ways in which information is communicated among clinicians and between patients and clinicians. Aside from the observational work by Hallström et al on patients following hip fracture, research on patient perspectives has involved survey and interview methods. Hallström et al observed 9 patients for approximately 20 h each, from admission in the emergency department to post-discharge. Patients often behaved passively, expected to tolerate pain, and perceived the side effects of pain medication as worse than the actual pain relief. They rarely complained, and analgesics were seldom given. Although pain protocols were available, nurses did not always follow them. This observational work helped to uncover behaviors and practices of which participating nurses and patients were unaware.

Although studies incorporating patient interviews and surveys can provide insight into patient perceptions, a limitation is that self-reported activities may differ from what actually occurs. For instance, the use of patient self-reported activities in individuals with cognitive impairment or sensory deficits or in the elderly or ethnic minority groups suggests the difficulties in accurately determining patients’ pain experiences. The purpose of this study was to investigate the strategies used by patients to bring about pain-management decisions in the postoperative setting.

**Materials and Methods**

**Design and Setting**

A single-group noncomparative design was used which included observations as the research method to examine pain activities in 2 surgical units of a metropolitan teaching hospital in Melbourne, Australia. The 2 surgical units were selected because the primary surgical procedures were likely to produce a greater intensity and quality of postoperative pain than the procedures performed in other units. The postoperative context involved patients undergoing gastrointestinal, ophthalmic, cardiac, respiratory, vascular, renal, gynaecologic, or musculoskeletal surgery. It also included patients with burn injuries who were awaiting surgery for skin grafting.

**Sample**

All registered nurses involved in direct patient care in the 2 surgical units were invited to participate (n = 76). We used a random number computer program to select a consenting nurse from the nursing roster for each observation to remove any selection bias. Fifty-two nurses were randomly selected to be observed in practice. Patients were eligible to participate if they were aged 18 years or over and had surgery that required a skin incision. Any patients suffering from confusion or dementia were still eligible to be included if their next of kin or guardian provided signed consent. Before each observation, we invited eligible patients allocated to the selected nurse to consent to the study, therefore enabling their medical records to be accessed for relevant demographic information. The total number of eligible patients was 364. Approval was not attained from 52 patients (14.3%) owing to difficulties in obtaining informed consent which included patient absence at the time of observation and the lack of an appropriate interpreter to explain the study. In total, 312 patients participated in the study.

The hospital and university institutional review boards approved the study. Informed consent was obtained from all nurses and patients participating in the study. Patients and nurses were assured that privacy and confidentiality of collected information would be maintained at all times.

**Procedure**

Six fixed observation times were identified for data collection: 0400-0600, 0800-1000, 1200-1400, 1400-1600, 1800-2000, and 2100-2300 hours. We selected these times because a previous pilot study showed that they covered important activities that affected pain management, including nursing shift overlap times, patient preparation for sleep, patient assessment times, patient hygiene and ambulation activities, medication rounds, ward rounds, nursing handover, availability of medical staff for consultation, and staff breaks. Each 2-h period was observed at least 12 times, resulting in the completion of 74 observations. Before the surgical procedure, patients received the usual preoperative education associated with pain assessment, pain targets, and analgesic techniques (Fig 1). Such education involved a nurse delivering information based on a standardized protocol documented in the hospital policy and procedure manual. No attempts were made by the investigators to alter delivery of this preoperative information.

The research assistant conducted all observations with minimal disturbance to staff and patients. One research assistant was used for the observations to prevent observer bias, and one of the investigators was present for the initial observations to ensure that appropriate data collection skills were used. Before the conduct of obser-
patients, the investigators met with the research assistant on several occasions to discuss the types of data to be collected. The investigators developed a structured data collection protocol, which was used for each observation, to aid training and ensure that consistent information was collected. A pilot study of 12 observations was conducted to ensure that health professionals in the 2 surgical units were accustomed to the research assistant’s presence. As the research assistant was required to gain written consent from patients involved in the study, this time was also used to practice strategies to gain rapport with patients and to alleviate feelings of anxiety.

The research assistant and the investigators presented a number of information sessions to all health professionals in the 2 surgical units to relay details about the study and provide opportunity to alleviate any apprehension. During these sessions it was emphasized that the investigator team was interested in documenting actual practice rather than making judgments about whether activities were performed well or not. Information sessions continued during the time of data collection, when health professionals were asked if the presence of the research assistant impeded their practice in any way. On all occasions, health professionals responded that because they were accustomed to the research assistant’s presence and she fitted into the ward routine, they were able to conduct their work in their normal way. All observations were recorded using a portable audirecorder with a head-mounted microphone. The use of a head-mounted microphone meant that the research assistant was able to whisper the clinical activities as they occurred. These whispers were picked up by the audirecorder but were barely audible to patients, nurses, and doctors as they went about their daily activities. The low audibility of the recordings contributed to an accurate reflection of clinical activities with minimal disruption by the research assistant. The research assistant used the head-mounted microphone by discretely pointing it in the direction of individuals when it was important to record direct quotes from them. This strategy also prevented distractibility by diverting attention away from the research assistant. One nurse-patient dyad was observed at any time to allow for accurate description of the strategies used by patients to receive pain-relieving measures.

During the course of one observation, the research assistant collected data on how a randomly selected nurse interacted with patients allocated in the care of that individual. At times, these observations occurred at the bedside, as the nurse and other health professionals interacted with the patient about pain-management issues. At other times, these observations occurred at the central office area, in corridors, and behind private office areas as the selected nurse collaborated with other health professionals on behalf of the patient. Following an observation, the research assistant asked clarifying questions of the participating nurse and these responses were also audiorecorded. By asking clarifying questions following the observations rather than during the time they occurred also helped to alleviate distractions. Audiorecorded data were transcribed verbatim and subjected to analysis. The detailed data collection schedule used in observations has been explained elsewhere.29 Briefly, the process involved the research assistant describing the patient’s appearance, detailing the activity undertaken by the patient and nurse at the time of observation, stating the time every 10 min, and stating the time when the nurse visited the patient for the first time. Using the head-mounted microphone, direct quotes relating to pain assessment and management were recorded in conversations between patients and nurses. Descriptions of all forms of verbal and nonverbal communication occurring between the nurse and patient at the bedside were recorded, noting the bed number of the patient involved. This process of identifying the bed number enabled further follow-up with demographic information about the patient. The total set of activities relating to pain, for example, mobilizing a patient postoperatively and completing a wound dressing, were also detailed thoroughly.

For this study, a patient strategy was defined as any contribution made by the patient to minimize or relieve the pain experienced. The strategy included either a patient- or nurse-initiated action. For example, the strategy may have involved patients asking the nurse for an analgesic to relieve the pain being experienced.
Table 1. Demographic Characteristics of Patients (n = 312)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Number</th>
<th>Percent</th>
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<tr>
<td>Diagnosis on admission</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>138</td>
<td>44.2</td>
</tr>
<tr>
<td>Integumentary (burns)</td>
<td>52</td>
<td>16.7</td>
</tr>
<tr>
<td>Renal/urology</td>
<td>29</td>
<td>9.3</td>
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<tr>
<td>Musculoskeletal</td>
<td>26</td>
<td>8.3</td>
</tr>
<tr>
<td>Vascular</td>
<td>25</td>
<td>8.1</td>
</tr>
<tr>
<td>Central nervous system</td>
<td>16</td>
<td>5.1</td>
</tr>
<tr>
<td>Gynecologic</td>
<td>14</td>
<td>4.5</td>
</tr>
<tr>
<td>Cardiac</td>
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</tr>
<tr>
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<td>0.9</td>
</tr>
<tr>
<td>Ophthalmic</td>
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<td>0.3</td>
</tr>
<tr>
<td>No. of comorbidities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>86</td>
<td>27.6</td>
</tr>
<tr>
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<td>113</td>
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</tr>
<tr>
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<td>74</td>
<td>23.7</td>
</tr>
<tr>
<td>≥5</td>
<td>39</td>
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Analysis

The computer software package NVivo (Version 1, QSR International, Doncaster, Australia) was used to systematically manage the data. Data in pain cases were categorized into specific themes pertaining to patients’ strategies for managing pain. Processes used to determine themes included reflection, thinking, dialog, questioning strategies, and comparative thinking. An independent research assistant was employed to undertake all data analysis. All members of the investigation team also separately analyzed the data to determine rigor of the themes. The investigator team had 100% agreement when they analyzed the themes independently.

Results

For the 52 nurses participating, 96.2% were female, their age ranged from 21 to 55 years (mean 27.5 years, SD 7.3 years), and their time since licensure to practice varied from 4 to 408 months (mean 63.5 months, SD 76.5 months). Their surgical ward experience ranged from 4 to 180 months (mean 38.4 months, SD 41.0 months). With respect to positions held in the ward, 79.8% were clinical nurses, and 13.5% were associate nurse managers. The remainder (7.6%) were employed as clinical nurse specialists, clinical educators, or nurse managers.

Of the 312 patients participating, 63.1% were male, their age ranged from 17 to 97 years (mean 56.7, SD 18.9 years), and observations were carried out between 0 and 57 days following the patients’ operation (median 3, Q25 1, Q75 8 days). The majority of patients were diagnosed on admission with a gastrointestinal condition requiring surgery (44.2%). Seven patients had a language barrier, which involved dysphasia, a hearing deficit, or difficulty with English. All patients had received a preoperative education session about managing pain following surgery. Other demographic characteristics of patients are shown in Table 1.

A total of 316 pain activities were observed, and 3 themes were identified relating to patient strategies for managing pain: acting as a passive recipient for pain-relieving measures, problem solving, and initiating active negotiation for pain-relieving measures (Table 2). In the health care institution under investigation, hospital policy indicated that health professionals should assess and reassess pain regularly, frequently, and systematically. Various self-reports for pain assessment were advocated in the policy, including the visual analog scale, faces scale, and numerical rating scale, depending on individual preference. Of the 316 pain activities, a pain assessment scale in the form of a visual analog scale or a numerical rating scale was used on 40 (12.6%) occasions. On these occasions the pain score obtained ranged from 0 to 10 (mean 6.5, SD 3.3). For the remaining 276 occasions, nurses used simple questioning to ask patients about their pain, for example, “How is your pain?” or “Do you need anything for pain?” Table 3 shows the regular and pro re nata (PRN) or “as required” analgesics prescribed to patients in relation to all 316 pain activities. Whereas 7 patient-controlled analgesia (PCA) and 6 epidural infusions were ordered during the postoperative period, a further 32 patients received a continuous morphine infusion by a volumetric infusion pump. In addition, 35 patients had a central venous catheter and 136 patients had a peripheral intravenous catheter, which enabled PRN analgesics to be administered parenterally. For extensive procedures such as abdominal and burns surgery, hospital policy recommended that analgesics should be prescribed regularly by volumetric pump, PCA, or epidural infusion for the first 24-48 h after surgery using the minimum effective dose. During this time, hospital policy dictated that PRN medications should be used for unpredictable or “breakthrough” pain. Gradually after the first 24-48 h, hospital policy recommended that patients should be weaned off continuous infusions but that intravenous access should still be available to
enable parenteral analgesics to be administered if required.

Table 4 shows the analgesics administered in relation to patient strategies for managing pain. In situations where patients participated as passive recipients, nurses mainly administered the nonopioid analgesic acetaminophen. In this form of decision making, nurses played a confirmatory role for scheduled analgesic doses that were of a regular nature, including PCA, epidural, and morphine infusions. In 32 situations, no analgesics were administered when patients were passive recipients.

With both problem solving and active negotiation, patients received a greater proportion of the PRN opioids morphine, pethidine, tramadol, oxycodone, and fentanyl compared with situations where patients were passive recipients. Table 5 details the specific causes of pain for patients involved in the 316 pain activities. Excerpts from the data are included to provide support for the themes.

**Being a Passive Recipient for Analgesia**

The strategy of patients being a passive recipient for pain relief occurred on 189 occasions. It was the most commonly observed strategy overall, happening 60% of the time during pain activities. In this strategy, nurses maintained full control of whether patients received analgesia, and communication occurred through a one-way path. Therefore, patients had little autonomy to influence the choices made. Three key subthemes were associated with this theme: first, patients agreed with the nurse to receive pain relief after being asked to describe their pain; second, some patients who were in obvious pain initially declined any offers of having an analgesic; and third, patients accepted offers of analgesics if they were able to take them at a later time.

The passive approach was commonly observed when nurses asked patients about their pain at particular times during the day. They were asked about their pain at convenient times for nurses, such as the start of the working shift, during the conduct of vital sign assess-
ments, and during nursing handovers. Some patients experienced pain at other times but they did not initiate communication with nurses. These patients exhibited nonverbal cues for pain, including guarding of the incision site, difficulty or reluctance to move, and difficulty in coughing and effective deep breathing. Instead, they waited to be asked about their pain and to be offered analgesia. In some situations, patients were cognitively alert and had no sensory deficits affecting their communication.

In other situations, patients who accepted nurses’ suggestion for pain relief could not speak English and had to communicate with a word board or by nonverbal techniques. At these times, nurses did not make any attempts to call a professional interpreter of the hospital, and patients did not request to receive assistance with language interpretation, as observed in the following excerpt during the nurse’s conduct of vital sign assessments.

The nurse is saying to the patient, ‘Any dolore [pain in Italian]?’ The patient replies, ‘Upset.’ . . . The patient is saying she vomited, ‘Yellow, yellow early in the morning.’ It is very hard to decipher what she is saying . . . The nurse is again asking, ‘Dolore, any problem?’ And the lady is saying, ‘A little bit.’ The nurse encourages her to press the PCA button and the patient replies that she has had a ‘big operation.’ The nurse agrees with her and says, ‘Bravo.’ The patient presses the PCA button as the nurse leaves the room. (Obs 14)

Observations also highlighted that some patients who were in obvious pain initially declined any offers of pain relief, which was then followed by agreement with nurses to have an analgesic. In most situations nurses were able to persuade patients to have the analgesic because it was a routine medication that was due to be taken at that time. In other situations, patients initially refused to have an analgesic but later agreed after nurses indicated they would change the medication. In the following example, the patient had been receiving PRN acetaminophen for his migraine, which had not alleviated the pain. When the nurse suggested having another medication he agreed to give it a try.

The nurse is checking with the patient about his migraine, and asking him whether he wants anything for it . . . He replies, ‘No, because nothing seems to be working.’ . . . She looks at the medication chart, and says, ‘What about the aspirin you had the other day as a single dose? I can give you 3 of those. That might help.’ He nods his head, agreeing that it is worth trying. (Obs 38)

In other situations, patients changed their minds about having pain relief after the nurse had returned to the bed area with an analgesic. In the following situation, the patient was admitted with testicular cell carcinoma, which required surgery and insertion of a continuous bladder washout. Following surgery he experienced considerable pain when his urinary catheter became blocked.

The patient is moaning and is in pain. The medical resident is just trying to unblock his catheter . . . The nurse is talking to the resident as he’s deflating the balloon of the catheter and asks the patient if he wants some pain relief. He says no. She says, ‘Are you okay?’ . . . The patient is in more distress and the resident is saying, ‘Give him 2.5 of morph.’ . . . The nurse returns with the morphine, gives it intravenously and tells the patient, ‘It will help with the pain.’ The resident is just telling the patient, ‘You’ve been through a lot today, a tough day,’ and the patient agrees. (Obs 17)

Patients were also observed to passively accept offers for pain relief if they were able to take an analgesic at a later stage. This situation occurred when patients complained of pain when asked, and nurses proposed administering an analgesic at the time stipulated on the medication chart. In the following example, the patient returned from the operating room about 4 h after having abdominal surgery and was already receiving PCA for pain relief.

The nurse is asking the patient about his pain. ‘It is not too bad. It just throbs when I move,’ he replies. ‘In the next three-quarters of an hour, I’ll give you some tramadol through your IV when it is due at 8 pm,’ she says . . . ‘And then when your pain is a bit better we can get you off the canvas [operating room transport linen],’ she adds. He says nodding, ‘Yes, that’s a bit uncomfortable, but I’ll wait until the pain is a bit under control.’ (Obs 65)

**Problem Solving With the Nurse**

Problem solving occurred on 73 occasions, and it was the second most common form of decision making, occurring 23% of the time during pain activities. For this strategy, nurses or patients initiated contact about a particular pain management issue and together they discussed possible solutions to problems raised. This form of strategy involved the ability to work collaboratively and share responsibility to determine pain treatment options that best suited patients. Three subthemes were evident in this theme: different types of pain requiring various analgesic measures, symptoms associated with pain requiring adjuvant measures, and patients having misconceptions about analgesics. In determining the effects of different types of pain, discussions between patients and nurses centered on preparing patients for various procedures or activities, including baths, dressing changes, ambulation, and sleep. It also included examining the source of the pain to determine whether to use pharmacologic or nonpharmacologic measures to treat the pain response.

In the following example, the patient was admitted with prostatomegaly, which required a continuous bladder washout. The nurse had sought out assessment information about his pain and the patient indicated that he was extremely uncomfortable because he felt like he wanted to void. Acknowledgment was made by the nurse that the urinary catheter had to be examined to determine if it was blocked.

The nurse is asking the patient to stand up, and telling him that the indwelling catheter is anchored really tight. The patient is moving around as he stands . . . and she is asking him if the feeling of a full bladder has gone because a whole lot of urine came out when he stood up . . .
‘Why does the tape have to be so tight?’ asks the patient. She is explaining that the catheter is taped tightly to support the area from added trauma. The patient says, ‘I still feel like passing urine.’ Now the nurse states she will get him something for the pain and then maybe it will go away. (Obs 21)

Problem solving also involved examining additional symptoms associated with pain that required the administration of adjuvant measures or changes to analgesic regimens. In some situations this aspect involved determining if a specific form of analgesic produced nausea and constipation. Patients indicated to nurses that because of nausea or constipation they were reluctant to consume an analgesic when distributed by nurses or to self-administer a PCA dose. Once problem solving had begun, nurses and patients worked together to change how PRN analgesics were administered to reduce the nausea or constipation experience. For example, solutions involving decreasing the analgesic dose that was likely to have caused the additional symptom and using one type of analgesic instead of another. Problem solving also involved nurses administering an antiemetic or aperient to a patient before analgesic administration.

Another aspect related to problem solving involved addressing patients’ misconceptions of analgesic use. Common misconceptions held were that opioid analgesic use could lead to addiction and that having the maximum dose of an analgesic could mean that pain relief is less effectively alleviated over time. This aspect of problem solving did not become apparent until nurses noticed that some patients kept refusing offers of analgesic relief or had only consumed a portion of their analgesic tablets, as observed in the following example.

The nurse comes to the male patient with burns and says, ‘I’ve got some paracetamol [acetaminophen] and tramadol for you.’ . . . The patient replies that he hasn’t taken the tramadol that was given to him earlier in the day and he has only taken the paracetamol. . . . He is concerned about having it if he doesn’t need it [tramadol] and wants to make sure it will keep on working when he does need it. The nurse says, ‘You need to let nursing staff know if you do or don’t take your medication so . . . they can discuss it with you and work something out.’ (Obs 61)

Initiating Active Negotiation for Pain-Relieving Measures

The third theme to emerge from observations was active negotiation of pain management with nurses. This strategy was observed on 54 occasions during pain activities. It was the least commonly observed decision-making strategy, occurring 17% of the time. In active negotiation, patients initially contacted nurses and patients made the final decision about pain management after considering possible solutions provided by nurses. The main difference between this strategy and problem solving was that in active negotiation patients took responsibility for making decisions about their pain management. Three subthemes were associated with this theme:

- Solving the problem
- Active negotiation
- Active problem solving

Solving the problem

Solving the problem also involved patients actively requesting particular analgesics. Patients often tied the request with a particular activity such as moving out of bed or going to sleep. In their requests they were very specific about the medication they wanted. For example, in one situation a male patient was about to go to the operating theater to have split skin grafts. He had received the oral nonsteroidal antiinflammatory drug diclofenac a few hours earlier and was now unable to have anything by mouth. After contacting the nurse, he requested intravenous morphine to alleviate the pain associated with his burns. Patients with communication barriers were also able to actively request pain relief. In the following example, the patient had a radical pharyngectomy and was unable to speak clearly. Yet he knew exactly what he wanted to relieve his pain and was confident enough to inform the nurse.

The nurse’s beeper has gone off . . . The nurse asks him [the patient] if he has a sore jaw. He nods his head and is speaking but it is difficult to understand. ‘What do you normally take?’ she continues. ‘Oxygen?’ she attempts to comprehend. He says, ‘No, MS Contin [slow-release morphine].’ He makes other comments that are difficult to understand. ‘Oh, when can I get you another one? I’ll get you it now if you like,’ she says. (Obs 18)

Active negotiation also involved patients deciding on which analgesic option to follow after they contacted nurses. These decisions concerned the most appropriate times to have pain relief so as not to interrupt overnight sleep. They also involved communication about the relative merits of various analgesics depending on the severity of pain. Patients then made decisions based on these options. In the following example, a male patient with right leg compartment syndrome had just begun structured physiotherapy sessions:

The man is on 6-hourly strict paracetamol [acetaminophen] . . . Yesterday he had a stat [single] dose of tramadol . . . The nurse is telling him, ‘I’ve got your 2 paracetamol and that will help with pain.’ . . . He is saying as he stretches his arms and legs, ‘Paracetamol does virtually nothing but they keep giving it to me. The tramadol seems to work . . . What’s been happening is I’m doing rehab and more so today. There is little point taking something that does not work’ . . . The nurse says she’ll have to ring up and get an order for tramadol. (Obs 56)

Active negotiation concerned patients attempting to change nurses’ pain management decisions. Some patients insisted on having an analgesic dose ordered in combination with an antiemetic. Changes were also negotiated about the times when patients would have their medications. Nurses sometimes assumed that patients did not want to be woken up to take their analgesic medications. However, some patients specifically requested to be woken up so that they would not experience pain at a later time. Negotiations were also
made on changing the type of analgesic medication nurses had intended to give:

The lady [with squamous cell carcinoma on the right leg] has just buzzed . . . the nurse says to her, ‘Are you all right?’ The patient responds, ‘My leg is a bit sore, the donor site is sore.’ The nurse asks if she wants anything for her pain because she is sore . . . ‘They give me Panadeine [acetaminophen 500 mg and codeine 8 mg] and Panadol [acetaminophen 500 mg], and they don’t help. They are useless. There is no point taking them. Yesterday, the fellow [other nurse] gave me Panadeine Forte [acetaminophen 500 mg and codeine 30 mg] and that worked all right.’ (Obs 69)

Discussion

The findings of this study enhance our understanding of how patients make decisions about managing pain in the postoperative setting. Patients adopted 3 strategies for managing pain: being a passive recipient, problem solving, and active negotiation. The most common strategy used was being a passive recipient to nurses (60%), and problem solving (23%) and active negotiation (17%) were less commonly employed. Patients demonstrated a relatively low degree of involvement in making decisions about their pain management with more than half showing complete deferment to the nurse.

In the postoperative environment, where patients were confronted with unfamiliar demands and expectations, it is not surprising that they frequently deferred to nurses to offer treatment choices for pain relief. Patients were admitted for surgical treatment of a particular condition and their subsequent pain was specifically related to this acute event. Therefore, the novelty of the situation and the severity of pain experienced may have encouraged passivity. The postoperative setting is characterized as an acute care environment where health professionals are required to make rapid decisions. As a result, patients typically experience a sense of helplessness while in hospital, which can also increase their hesitation in communicating their health needs. Patients may have felt uncertain about how to approach the pain decision, preferring to defer to nurses. Because increased pain levels can be associated with fear, patients might have been unwilling to speak with nurses to discuss their need for pain relief. Nurses should attempt to understand this fear and use information gained to sensitize themselves to pain assessment cues which can be used to develop proactive communication mechanisms to allay patient fear.

Problem solving between patients and nurses occurred on 23.0% of occasions. While less commonly observed than passive deferment, problem solving was an effective means of increasing patients’ knowledge about therapeutic and adverse effects of analgesics and addressing misconceptions about pharmacologic pain relief. This strategy allowed for favorable outcomes because nurses were willing to present information according to the specific circumstances affecting patients at the time, for example, experiences of constipation and nausea in association with analgesic administration. By collaboratively working together to determine appropriate solutions and nurses using a level of explanation that patients understood, patients were able to exhibit some level of control of their pain and associated symptoms.

Active negotiation was only observed on 17.2% of occasions; however, its presence demonstrated the importance patients placed on involving themselves in decisions. Patients who exhibited active negotiation understood their pain situation and were able to reason effectively without undue fear about consequences. In contrast to those who demonstrated passive tendencies, patients with active negotiating abilities confidently determined how certain choices about pain management led to particular outcomes, and built a repertoire of treatment choices consistent with their goals for achieving maximum pain relief. With increasing access to health care information, patients are becoming more aware of available options, and are also demanding greater involvement in decision making.

Particular characteristics seemed to differentiate patients who demonstrated passive decision making from those who participated in problem solving and active decision making. Particular patients used the same approach for decision making at various times rather than employing different approaches at different times. This finding demonstrates that a patient’s personality, beliefs, and values may have contributed to the portrayal of a specific strategy. Those involved in problem solving demonstrated willingness to collaborate with nurses in analyzing the merits of different treatment options. Those who were involved in active decision making were able to proactively propose a number of analgesic alternatives based on their degree of pain, demonstrate their preference for particular analgesics, and talk confidently about their past pain experiences. On the other hand, patients who participated in passive decision making showed little interest or limited confidence in proposing treatment options, preferring to defer to the nurses’ opinion. During preoperative education sessions, the decision-making strategy a patient is likely to identify with should be determined. Patients who are likely to demonstrate a passive recipient role can be given a structured plan to help them incorporate more problem solving and active approaches in communicating needs.

From the study, it appears that passive requests result in poorer pain management. Patients who used problem solving or active negotiation strategies were more likely to receive a PRN opioid analgesic, such as morphine, pethidine, tramadol, or oxycodone. On the other hand, patients who acted as passive recipients were more likely to receive nonopioid analgesics, such as acetaminophen. In 32 situations, passive recipients had no analgesic administered when the nurse indicated that analgesic administration would be deferred to a later time. Administration of scheduled analgesic doses through PCA, epidural, or intravenous morphine infusions did not require active patient input, and in these situations the nurse largely confirmed with the patient that a continuous form of pain relief was given. Conversely, the PRN
approach for managing pain encouraged passivity because it required vulnerable patients to request an analgesic, which should already have been routinely provided. Continuous forms of analgesics should be administered to prevent patients from having to ask for pain relief during the immediate postoperative period. Similarly, patients should be educated about problem solving and active strategies to help them deal with any breakthrough pain that may occur. Health professionals also need to be more diligent in proactively titrating analgesics against patient response.

Two major factors are fundamental to patient involvement in decision making about pain alleviation.14 First, consideration needs to be given to how health professionals and patients decide on the range of treatment possibilities from which they are making a choice. In practice, this determination relates to whether patients are indeed given a range of treatment options.14 In the current study, nurses focused on nonopioid analgesic options prescribed on the medication order chart, particularly for situations where patients deferred to the nurse. It may be possible that nurses were not familiar with certain treatment options for pain relief or had limited experience or expertise in using various analgesic measures. Furthermore, although nurses educated all patients with a preoperative education session, this preparation did not seem to lead to a high incidence of problem solving and active negotiation.

Second, effective communication must be supported between the health professional and patient if shared understandings about pain treatment options are to become a reality.43 More specifically, patient involvement relies on intricate balancing acts in communication in relation to responding to anxiety about pain experiences, providing opportunities for patients to share responsibility for analgesic options,43 educating patients about relevant aspects of pain management, and helping patients to incorporate their preferences into treatment decisions.15 An important component of effective communication is nurses ensuring they have accurate information about patients’ pain experiences. Although hospital policy indicated that pain assessment should be undertaken regularly using validated tools, a pain scale was used in only 12.6% of situations. A possible reason for the apparent lack of attention paid to assessment cues has been detailed in the work of Manias et al.30 In that research, nurses did not prioritize pain assessment, and it was often considered less important compared with other activities. Examples of prioritized activities included the completion of medication rounds, the conduct of vital sign observations, and completion of wound dressings. Pasero and McCaffery33 have provided an innovative solution to the lack of accountability through the establishment of comfort-function goals. When determining care needs, nurses can explain postoperative goals that are essential for patient recovery, which may include being able to breathe deeply or ambulate around the bed area. Guiding patients to select a pain rating would help them to accomplish their goals. Effective communication then becomes a vital component of patient decision making, and not merely an instrumental support to care.

The present study focused on the strategies patients used for managing pain; patients were not asked about their satisfaction with the decision-making process or their preferred strategy for decision making with nurses. A further limitation is that nurses and patients who participated may have had an increased awareness of their pain management activities owing to being observed.6 The results demonstrated that in over half of the pain activities, strategies involved patients acting as passive recipients for pain relief, which indicated that analgesic requirements were determined in a reactive rather than proactive manner. It is therefore unlikely that patients changed their behavior for the purposes of the study.

This study demonstrates implications for clinical practice. Health professionals need to be more active in assisting patients to determine the effects that surgery could have on producing pain. Talking with others that have undergone the same procedure may help some patients to anticipate their own adaptation to the pain experience. Health professionals can support patients by presenting analgesia treatment options clearly and in ways that encourage active negotiation and collaborative problem solving. In identifying patient strategies it is possible to determine whether comfort-function goals have been achieved and to prioritize particular areas for improvement.19,32,35 Creating an atmosphere that generates trust and confidence is fundamental for encouraging patients to become effective and active participants in the management of pain.

References

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