

Nursing Reflective Essay

*This example of a reflective essay is presented in association with **Price, B and Harrington, A (2013) Critical Thinking and Writing for Nursing Students, London, Learning Matters**. Readers are introduced to the process of critical and reflective thinking and the translation of these into coursework that will help them to achieve better grades in nursing courses. Stewart, Raymet, Fatima and Gina are four students who share their learning journey throughout the chapters of the book. In this essay on the assessment of pain, **Raymet** demonstrates her reflective writing skills near the end of her course. Raymet had by this stage written several reflective practice essays and gained good marks. This time though she was encouraged to deepen her reflections, speculating selectively on how the account of pain experienced by a patient (Mrs Drew) might help her to work more creatively with patient perceptions and reported needs.*

N.B. Remember, copying essays such as this, submitting them as a whole or in part for assessment purposes, without attributing the source of the material, may leave you open to the charge of plagiarism. Significant sanctions may follow for nurses who do this, including referral to the Nursing and Midwifery Council.

Assessing Mrs Drew's Pain

Mc Caffery and Pasero (1999) state that pain is what the patient says it is. If we accept that point, then nurses need to explore the patient's perceptions of pain, as well as their report of experiences. The two are not quite the same. Patients may report their pain in a variety of ways, dependent on the nature and the intensity of pain and the context in which it is felt (e.g. whether they are ever distracted from the pain). Their perception of pain is a little more though and it includes the meaning that the pain has for them. It includes explanation of why the pain is there in the first place, what it indicates about their body and what it could suggest might happen in the future (getting better, getting worse). The nurse assesses the account of pain shared by the patient, and this may be given in the form of a story. This is how it began, this is how it felt, this is what that meant to me and this is what I did about it (Mishler et al. 2006)

In this essay I explore the assessment of pain as conducted with one 60 year old patient whom I will call Mrs Drew. Whilst the essay describes an assessment of pain with a single patient, I try to share too some ideas and questions that this provokes within me about pain assessment more generally. Mrs Drew made me think about other patients, future assessments and what I had to do as a nurse to help patients. To help structure this essay I use the framework described by Gibbs (1988). Whilst the episode concerned relates a stage in Mrs Drew's illness when she challenged her treatment protocol, it also includes some of the memories and thoughts that this patient refers to regarding her earlier illness and past ways of coping with pain. In particular, it prompted me to question to what extent I as a nurse should recommend analgesia, drawing on what I had been taught about the

effective control of pain. I had learned that it was better to control rather than to chase pain (e.g. Mann and Carr, 2006; Forbes, 2007).

Mrs Drew was diagnosed with lung cancer a year earlier and had initially had her illness treated by chemotherapy. This had helped her to achieve a remission that lasted for nearly ten months (Hunt et al, 2009 describe the prognosis of this disease). The cancer had returned though and spread to her spine and it was here that she experienced most of her pain. It was at this stage that the doctors explained that her care would now be directed towards her comfort rather than a cure—to which she had replied, ‘you mean palliative care’. Mrs Drew was supported at home by her husband Neil and visited on a regular basis by community based nurses to whom I was attached as part of my student nurse training. She was prescribed oral morphine and could decide within stated limits how many tablets she could take in any one 24 hour period.

The situation

I had visited Mrs Drew on several occasions over the period of a month when the community nurse and I were confronted by a tearful patient who announced that she did not wish to take the oral opiates quite as often as we were recommending. As she spoke she held her husband’s hand tightly, looking across to him as she described her experiences and feelings about the matter. Yes, there had been some bad nights when the pain had woken her and she had to sit up and watch television to try and distract herself. Yes, sometimes the pain made her feel nauseous, but she was alarmed at how frequently she was taking the ‘pain tablets’ and how this made her feel about herself. However well meant the medication was, it didn’t feel dignified to be so reliant on drugs, or quite so sleepy and unresponsive for such a high percentage of the day. Whilst the analgesia was working well when she took the tablets, the quality of life wasn’t what she wanted.

The community nurse listened patiently to Mrs Drew and then explained that it was normal to have panic moments about such medication. Morphine had a reputation, one that people associated with misuse of drugs, rather than their therapeutic use. Used on a regular basis, the drug wouldn’t cause addiction and it would provide a great deal of reassurance to Mr Drew as well. The community nurse stated that she was quite sure that he respected his wife’s need to sleep when she wished and to build the rhythm of the day around her needs.

At this point Mrs Drew shook her husband’s hand, and said, ‘tell her...tell her what we’ve talked about!’ Mr Drew then explained that his wife was used to dealing with pain, she had suffered recurrent pain in her neck and shoulder after a road traffic accident some years before. The pain had sometimes been severe, but he had massaged her shoulders and used heat packs that she found soothing. They had decided that they wished to use this technique now, keeping the morphine for absolute emergencies, when she was losing sleep and couldn’t eat as a result of the discomfort.

The community nurse assured them that they were in charge of the analgesia and would be allowed to make their own decisions. She started to make notes though, and announced that she was making a referral to the cancer pain clinic, something that would help them to take stock of the situation. There was very good reason to suppose that this might be a problem associated with choosing the right dosage of the morphine, rather than using supplemental pain relief measures. Mrs Drew responded sharply, ‘You’re not listening to me though Jane (the community nurse’s name—a pseudonym is used here), I want to use heat packs instead of morphine, at least during the

day. I want to be more alive with my husband.’ The community nurse assured Mrs Drew that she had heard what she had said and respected her point of view. There would though be nothing lost by using the clinic to gain a further check on this matter. With that she excused us, explaining that we had a further appointment that morning and we left, having checked that Mrs Drew had a sufficient supply of her different medicines.

As we walked to the car the community nurse empathised with Mrs Drew’s plight, saying that if she had lung cancer she would probably grasp at straws too. She would reach out for things that seemed more normal, and then observed, ‘but this isn’t normal is it, the pain she has isn’t normal. It’s not just a whip lash injury and old age.’

Feelings

I remember that during this episode feeling a mixture of confusion, surprise, anger and impotence. Mrs Drew had surprised me by the way she had spoken, using what seemed to be a planned announcement. They had waited for and perhaps rehearsed this moment. Nothing in my experience to date had prepared me for such an encounter, at least in such circumstances, where we as nurses were so obviously working to support the patient. It was only later that I called the episode a confrontation. Mr and Mrs Drew had confronted the community nurse and I had been the largely silent witness to the event. As the discussion proceeded I remember making supportive noises, remarking how useful heat packs sometimes were and glancing across at Jane, who seemed to be signalling with her expression that I should leave this debate to her. I was trying to read her reactions to the Drew’s points and concluded that if I couldn’t support her arguments to the patient, then I should remain silent. There were issues here that I perhaps hadn’t enough experience to deal with, at least, whilst ‘thinking on my feet’.

My initial anger (with Mrs Drew for not acknowledging all that we were trying to do) quickly became displaced towards my colleague Jane. During the event I couldn’t explain why that was, but afterwards, when I made notes, I realised that it was because she seemed to have set the agenda in her own mind and to be requiring the patient to comply with concerns of her own. Put rather crudely, Jane seemed to be saying, listen I know about these things, this is a phase, an anxiety; you can work through all this. I believed at this point that she had missed the significance of the event, the way in which the Drew’s had arranged the conversation. For them, this was not a phase at all, but a considered and very important decision, one that they wanted the nurses to accept (Freshwater, 2002 and Edwards and Elwyn, 2009 emphasize the importance of negotiated care planning).

My feelings of impotence were associated strongly with my lack of clinical experience. I have met this before. No matter how many placements I do, no matter how good the mentoring I receive, I keep meeting situations where I am unsure about how to respond next. I feel younger, less knowledgeable than I should be at this stage in my training. I want to reassure patients, to support colleagues and to give good advice, but there is not enough confidence to do that. If I felt unsettled and uncertain about Jane’s response to the Drew’s, right then I couldn’t easily explain that. I couldn’t offer a second opinion, couldn’t suggest an idea that might help support the patient. To my annoyance I couldn’t manage that either as we left the house. Jane had made some fair points, she

clearly seemed concerned about the patient's needs, but perhaps she hadn't spotted the right need—for Mrs Drew to determine in greater part how she dealt with her illness.

Experience evaluated

Afterwards, this short episode prompted doubts and debates about several important aspects of nursing for me. Setting aside the etiquette of learning in clinical practice, not challenging a qualified nurse in front of a patient, there were problems here associated with supporting patient dignity, with my assumptions relating to analgesia and pain control strategies, and I realised, with my assumptions about types of pain and who had the expertise to define these.

Dignity is more than simply using the appropriate terms of address, protecting the privacy of patients and attending to their expressed concerns (Price, 2004). It is about clarifying the ways in which they live and accommodate illness or treatment. It is about finding out what benchmarks they use to say that 'yes, I am doing well here, this makes me feel good about myself'. Upon reflection, I sense that we on this occasion had not worked hard enough to discover how Mr and Mrs Drew define quality of life, or being in charge of their situation. We were more concerned with providing resources, sharing research or theory about medication and questioning the familiar misconceptions associated with morphine. To put it simply, we were 'missing a trick', reading the encounter as something that had happened many times before—the report of problems or anxieties, a request for help, rather than a decision that the patient and her carer had already come to. Reading situations well seemed, with the benefit of hindsight, to be the first basis for dignified care. 'What is happening here, what will help the patient most?' were questions that we perhaps assumed that we already knew the answer to.

I realised that in my training I had already accepted the argument that patients would wish to remain pain free come what may and that the tackling of fears about prospective pain, was something that nurses engaged in. I assumed that because cancer pain represented such a major threat, because it was greater and more all encompassing, that there was little or no doubt that it should be removed. What was so unsettling, and took so much time to examine, was that Mrs Drew acknowledged the possible severity of metastatic cancer pain, but that she still preferred to respond to it using measures that had worked for her whiplash neck injury. Mrs Drew was willing to trade off a pain free state for something that gave her a greater sense of control and which perhaps enabled her husband to express his support for her in a very tangible way (preparing heat packs, massaging her back, rather than simply giving her the tablets). Mr and Mrs Drew questioned all my assumptions about best analgesia practice, and seemed to write a large question mark on the textbooks I had read about chasing rather than controlling pain in palliative care situations (Mann and Carr, 2006).

Reflections (learning opportunities)

The episode with Mrs Drew left me uncomfortable because my past approach to pain management was theoretical. I (and I believe Jane too) regularly made use of science to decide what could be done as regards pain relief and to assume that patients would wish to achieve all of those benefits. This wasn't about local applications of heat versus morphine, Mrs Drew could use both, it was about choice and how patients made choices—why they reached the decisions that they did. It was for me, about accepting very personally, that providing that patients are given all the relevant facts, alerted

to the options, that they really are able to make choices that work for them. The very fact that Mrs Drew's illness was now incurable, that she and her husband usually tackled pain together, meant that her solution to the challenge was different to those that many other patients arrived at. Having dealt with this pain for some time, knowing that it could and probably would get worse, meant that she was better equipped than other less experienced patients to make a decision here.

This took nothing away from the benefits of sharing further discussion with pain clinic experts. I thought, Mrs Drew will stand her ground, she will insist on doing things her way if her husband is strong too. What it did highlight though was the importance of listening to patients, hearing how they perceive pain, how they narrate not only the pain but what they did about it. In this instance the narration was all about dignity, and coping, and finding ways to help one another and how this enables us to feel in the face of such a terrible illness. So, in telling us about her pain, what she did about it, using morphine when it was 'absolutely required', Mrs Drew was not reporting her ignorance of what could be achieved if the medication was used differently, but what she preferred to do as it enabled her to achieve different goals. Mrs Drew's goals were about liveliness, alertness and stoicism, showing that she could bear at least a measure of pain.

I wondered why I hadn't listened carefully enough to such a story? Was it because of time pressure, or perhaps complacency, that Jane and I felt that we already knew what account would be shared? Did we think that the patient would ask for help, more help, as the pain continued? If so, then our guesses had prompted us to behave as experts, and problem solvers, on the patient's behalf. Perhaps hearing a patient narrative is about discovering what sort of role they would like you to fulfil. If so, then it might be a difficult role. I thought hard about how hard this was for Jane. She was going to be asked to witness Mrs Drew's future pain, one that was now less perfectly controlled. She was going to be asked to reassure, to suggest measures that might help, without reminding the patient that she 'already knew that you couldn't manage pain *that way!*' When I think about it now, that is very stressful for a nurse. It is about caring and allowing patient's to make choices that we personally might not make.

Conclusions

I have drawn then three conclusions from the above reflection.

First, that being patient centred is never easy and requires real listening and interpretation skills. My criticism of what Jane chose to do, to try and dissuade Mrs Drew from a course of action, recommending further appraisal of the situation, is an easy one to make. Nurses confront situations such as this relatively unprepared and react as considerately as possible. It is easy in hindsight to recommend other responses, a further exploration of what motivated Mrs Drew's pain management preferences.

Second, that experience can be a valuable teacher, the equal of textbooks. If nurses are interested in care, then we should be concerned with the sense that patients make of their own illness, the treatment or support that they receive. We need to understand what patients have to teach us and have to acknowledge that this means that we won't always seem in control ourselves, expert and knowledgeable. Our expertise might be elsewhere, helping patients to reach their own decisions.

Third, that one way to understand patient perspectives on illness or treatment, on pain management in this example, is to hear how they talk about the situation. How do they describe the pain, how do they refer to what they did about it? The way in which the story is shared, how we coped, how this made us feel, is as important as the facts related. Sometimes a patient needs to feel stalwart, even heroic in the face of illness.

Future care

It would be foolish and unprofessional to recommend to other patients that they might not wish to remove pain, or that overcoming pain doesn't always mean we don't continue to experience it. For every Mrs Drew there may be many other patients who would welcome the complete removal of pain, so that they can die calmly, quietly, with their own version of dignity. But it does seem to me, that it will be worth thinking about the diversity of patients and how they prefer to cope when I assess pain and help manage this problem in the future. I won't be able to walk away from the responsibility of debating whether I have explained all that I could, detailed the strengths and limitations of different ways of coping. I will need to find reflection time to ponder what patients have said and if necessary to go back and say, 'I've been thinking some more about your words last week..' knowing that this doesn't make me any the less professional.

References

Edwards, A and Elwyn, G (2009) *Shared decision-making in health care: achieving evidence-based patient choice*, 2nd ed. Oxford, Oxford University Press

Forbes, K (2007) *Opioids in cancer pain*, Oxford, Oxford University Press

Freshwater, D (2002) *Therapeutic nursing: improving patient care through self awareness*, London, Sage.

Gibbs G (1988) *Learning by doing: a guide to teaching and learning methods*, Oxford, Oxford Polytechnic Further Education unit

Hunt, I., Muers, M and Treasure, T (2009) *ABC of lung cancer*, Oxford, Wiley-Blackwell/BMJ Books

Mann, E and Carr, E (2006) *Pain management*, Oxford, Blackwell

McCaffery, M and Pasero, C (1999) *Pain: Clinical manual*, Mosby, Philadelphia

Mishler, E., Rapport, F and Wainwright, P (2006) *The self in health and illness: patients, professionals and narrative identity*, Oxford, Radcliffe Publishing Ltd

Price, B (2004) Demonstrating respect for patient dignity, *Nursing Standard*, 19(12), 45-51