

**The Uptake of Guidelines for Cancer Pain Management
and Its Impact on Nursing Practice in South Korea:
A Critical Ethnography**

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STATEMENT OF ORIGINALITY

I hereby certify that the work embodied in the thesis is my own work, conducted under normal supervision. The thesis contains no material which had been accepted, or is being examined, for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made. I give consent to the final version of my thesis being made available worldwide when deposited in the University's Digital Repository, subject to the provisions of the Copyright Act 1968 and any approved embargo.

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Date:

21. 09. 2018

Miran Kim

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All the glory and praise to my God who has used this journey as a great opportunity to grow me up not only professionally but also personally.

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Abbreviations

The following abbreviations have been used throughout the thesis.

| | |
|----------|---|
| AACPMGWP | Australian Adult Cancer Pain Management Guideline Working Panel |
| ACS | American Cancer Society |
| AGC | Advanced Gastric Cancer |
| AGREE | Appraisal of Guideline for Research and Evaluation |
| AN(s) | Assistant Nurse(s) |
| APS | American Pain Society |
| CE | Critical Ethnography |
| CANO | Canadian Association of Nurses in Oncology |
| CCNS | Cancer Care Nova Scotia |
| CIHR | Canadian Institute of Health Research |
| CIT | Critical Incident Technique |
| CPMG | Cancer Pain Management Guideline |
| DHUMC | Daehan University Medical Centre |
| DON | Director of Nursing |
| ED | Emergency Department |
| EBG(s) | Evidence-based guideline(s) |
| EBP | Evidence-based practice |
| EMR | Electronic Medical Record |
| ENR | Electronic Nursing Record |
| FLACC | Face-Legs-Activity-Cry-Consolability Scale |
| GS | General Surgery |
| HIRAS | Health Insurance Review and Accreditation Service |
| HIS | Healthcare Improvement Scotland |
| IARC | International Agency for Research on Cancer |
| IASP | International Association for the Study of Pain |
| ICN | International Council of Nurses |
| IRB | Institutional Review Board |
| JCI | Joint Commission International |
| KCSG | Korean Cancer Study Group |
| KSHPC | Korean Society for Hospice and Palliative Care |
| LCI | Long-term Care Insurance |
| MA | Medical Aid |
| MHW | Ministry of Health and Welfare |
| MMAT | Mixed Methods Appraisal Tool |
| MO | Medical officer |
| MTX | Methotrexate |
| NCC | National Cancer Center |
| NCCI | National Cancer Control Institute |
| NCCN | National Comprehensive Cancer Network |
| NCI | National Cancer Institute |
| NE | Nurse Educator |
| NHI | National Health Insurance |
| NHIC | National Health Insurance Corporation |
| NHIS | National Health Insurance Service |
| NIPS | Newborn Infant Pain Scale |
| NP(s) | Nurse Practitioner(s) |
| NPIs | Non-pharmacological interventions |
| NRS | Numeric Pain Rating Scale |
| NUM(s) | Nurse Unit Manager(s) |
| NTGB | Nursing Task Guidebook |
| O | Objective data |
| OECD | Organisation for Economic Co-operation and Development |
| ONS | Oncology Nurses Society |
| P | Plan |
| PAFS | Pain Affect Faces Scale |
| PCA(s) | Patient Controlled Analgesics |

| | |
|-------|--|
| PCC | Patient centred care |
| PCN | Percutaneous Nephrolithotomy |
| PI | Principle Investigator |
| PMIS | Pain Management Information Sheet |
| PRN | Pro re nata |
| PQRST | position, quality, relieving or aggravating factors, severity and timing |
| PS | Plastic Surgery |
| RISS | Research and Information Sharing Service |
| RN | Registered Nurse |
| SIGN | Scottish Intercollegiate Guidelines Network |
| ST | Superordinate theme |
| TRAM | Transverse rectus abdominis myocutaneous |
| UN | United Nation |
| WHO | World Health Organisation |

Key to transcripts

The following abbreviations and conventions have been used throughout the thesis, where excerpts from the participants' transcripts have been used.

| | |
|--|--|
| Names | Pseudonyms are used to refer to participants. The only true name within the data is the researcher's |
| <i>Indented italic text</i> | Indicates excerpts from the participants transcripts |
| ... | Indicates a pause contained in the original material |
| ...//... | Material edited from the original for clarity |
| [square brackets] | Researcher's comments, added to provide clarity or explanation |
| Bold | Indicates a word, phrase, or sentence relevant to theme(s) |
| (Name and/or TL/TC/TM and/or A-VII-20) | Indicates the location of the excerpts |

ABSTRACT

Given cancer causes pain and suffering impacting the quality of life of patients the use of evidence-based guidelines (EBGs) for pain management is essential for improving patient experiences. The Cancer Pain Management Guideline (CPMG) in South Korea was introduced in 2004 following many concerns of healthcare professionals, including nurses, about the suffering of patients with cancer due to pain. South Korean healthcare professionals believed that the introduction of the CPMG would influence the care and treatment of patients with cancer pain.

This study aims to critically explore the impact of the introduction of the CPMG on clinical practice of the nurses in cancer care facilities. Further, the study aimed to uncover the roles and functions of nurses and the factors that influenced or hindered the adoption/spread/uptake of the CPMG.

To answer the research question '*What is the impact of the introduction of the Cancer Pain Management Guidelines on nursing practice in South Korea healthcare context?*' Critical Ethnography was deemed the most appropriate methodology, because it allowed the researcher to observe the practice, examine documents, explore reports on experiences and critically examine the emergent themes from the storylines provided by the 10 nurse participants working in acute cancer care units in South Korea.

A total of 13 themes were classified into three superordinate themes and some themes contained further subordinate themes, which included themes relating to the uptake of the CPMG, nurses' usual practices and the nurses' experiences of managing pain.

There was little evidence of the impact of the introduction of the CPMG on nursing practice. The findings also revealed that nurses' usual practice was observed as 'transactional' and not always demonstrating an advanced level of decision-making informing practice to serve the patients' true needs based on evidence. Nurses themselves were not evaluating their own practice and embracing a comprehensive set of roles and functions related to pain management. Nursing practice was influenced by various issues in terms of nurses' decision-making. These included: 1) the medically driven nature of the development processes for a set of guidelines suitable for use as EBGs; 2) an absence of evidence of the organisation's role in support of EBGs and subsequent support for quality care and a supportive work culture; 3) the valuing of the nursing contribution, and an apparent undermining of the nurses' role by all involved; and 4) lack of patient-family centred care aligned with the concept of a therapeutic partnership and mutual respect.

Recommendations include the need for an integrated approach at four levels: Policy informing the national guidelines; organisational support for implementation of EBGs; involvement of nurses in the EBP through the use of EBGs; and recognition of patients and families' involvement in education and decision-making about their care.

CHAPTER ONE

INTRODUCTION

1.1. Background of the Study

South Korea is a country, where rapid development and changes in many aspects including healthcare have been occurring since the late 1990s. Improving quality of care and patient safety have become critical issues in the Korean healthcare system and there has been much effort to address those issues (Organisation for Economic Co-operation and Development [OECD], 2012). In particular, the care and treatment of patients with cancer has attracted significant attention, as there has been an increase in patients with cancer and recognition by healthcare professionals including nurses, of their health issues and concerns (National Cancer Control Institute [NCCI], 2017). The NCCI (2017) reported that cancer was the leading cause of death in Korea with one in every four people diagnosed with cancer. Patients with cancer suffer from the disease and its treatment, and many also suffer with unrelieved and intractable pain (Byun & Choi, 2013).

The 'Cancer Pain Management Guideline (CPMG)' was developed in 2004 following the many concerns of healthcare professionals, including nurses, about the pain and suffering of patients with cancer. The use of evidence-based guidelines (EBGs), as a model of patient care for people with cancer, is considered an essential element in improving care quality through improving patient outcomes (Bhatnagar & Gupta, 2015; Dy et al., 2008). The development of the CPMG as EBGs was an integral part of the changes that Korean society was experiencing in an effort to improve the quality of care provided within the healthcare system. The CPMG has been reported as the precursor to major changes in cancer pain management practices, particularly in terms of the use of pharmacological interventions (Lee, 2007).

The researcher's personal experiences working with patients who were diagnosed with cancer and who experienced un/under-managed pain prompted critical reflections and the inquiry reported in this thesis regarding the uptake of the CPMG. Of concern to the researcher was i) whether the CPMG was used in nursing practice; and ii) the nature and extent of the uptake of the guidelines, in particular, the influence on nursing practice. Of note was the limited number of studies that showed the uptake of the guidelines in South Korea, and the impact on cancer pain management practices especially for the nurses who provided care for patients with cancer (Cho, 2009; Yu, 2011). Although these two studies stated that the CPMG had positive influences on cancer pain management, they did not clearly show if and how the implementation of the CPMG influenced nursing practice. Given the central role that nurses play in providing care for patients with pain related to cancer and its treatment, it is important to critically examine/explore the experiences of nurses following the introduction of the CPMG.

1.2. The Aims of the Study

This study aims to critically explore the impact of the introduction of the CPMG on clinical practice of the nurses in cancer care facilities. By critically exploring the experiences of nurses who provided care to patients with cancer, the study sought to identify and understand "*culturally engrained knowledge, behaviour and shared understandings*" (Calhoun, 1995, p. 5). Further, the study aimed to uncover the roles and functions of nurses and the factors that influenced or hindered the adoption/spread/uptake of the CPMG.

1.3. Cancer and Cancer Pain

1.3.1. Prevalence of cancer and cancer pain

Cancer is one of the most significant diseases as it is the second leading cause of death and impacts the increasing annual economic cost of health services globally (World Health Organisation [WHO], 2017a). It was reported that 14.1 million people in the world have new diagnoses of cancer (all types, except non-melanoma skin cancer) and that 32.6 million people were living with cancer for the last five years of their lives in 2012 (International Agency for Research on Cancer [IARC], 2017). Stewart and Wild (2014) in their report for the WHO reported that South Korea had one of the highest cancer incidence rates in the world. Of concern, is that in the current report of the National Cancer Institute (NCI, 2017), it was estimated that there would be a 50 percent incremental increase in cancer cases worldwide between 2012 and 2030. According to a group of researchers who monitored cancer related statistics including incidence and prevalence rates in South Korea, the prevalence rate for those patients with cancer had increased, despite the decreased incidence rates: they attributed these rates to the increased survival rates (Jung et al., 2015; Jung et al., 2017).

With the high prevalence and increased survival rate, cancer pain has become an ongoing challenge for patients, families and healthcare professionals including nurses. Pain can occur at any stage of the disease, arising from the cancer itself, from pre-existing conditions and from the aggressive cancer treatment regimens associated with chemotherapy, radiotherapy and surgery. Increasing cancer prevalence rates means increasing the chances of pain experience among those patients with cancer. Not only are there growing prevalence and mortality rates associated with cancer, but also the accompanying symptoms, including pain, decreases the quality of life for the patients and those around them (Lee, 2007; WHO, 2011).

Research particularly shows that unresolved pain can lead to negative patient outcomes among cancer patients. The UN News Centre (2007) cited more than 4.8 million cancer patients worldwide who suffered from moderate to severe pain, received no treatment.

The Human Rights Watch (2009) reported more than 50 percent of cancer patients were experiencing cancer pain and/or pain symptoms, and that 60 to 90 percent of advanced stage cancer patients were in severe pain. Van den Beuken-van Everdingen, Hochstenbach, Joosten, Tjan-Heijnen, and Janssen (2016) conducted a systematic review and meta-analysis to update international cancer pain prevalence with 122 international studies, and found a pain prevalence rate between 39.3 percent (post curative treatment) and 66.4 percent (current advanced, metastatic, or terminal disease). They highlighted that the pain prevalence rate was increased from their previous review, which they conducted with articles that were published for the past 40 years at the time of the review (Van den Beuken-van Everdingen et al., 2007). Between those two studies in 2007 and 2016, there have been several initiatives to enhance awareness in both healthcare professionals and the general public in terms of managing cancer pain such as installing information in social media and magazines from organisations directed to patients. However, they found inadequate management of cancer pain appears to be evident within contemporary studies, regardless of such efforts to improve patient outcomes in managing cancer pain (Van den Beuken-van Everdingen et al., 2016).

There are few studies presenting details on cancer pain prevalence in South Korea during the last two decades. A survey conducted by Yun et al. (2003) in 2000 to estimate prevalence, severity and management of pain among those patients with advanced stage of cancer in South Korean, included 655 participants from 8 university affiliated hospitals in South Korea. This study revealed 70.8 percent of patients reporting pain and 63.6 percent of these patients actually rated their pain 5 or greater than 5 on a scale of 0 to 10. In 2001, a group of physicians conducted another survey in five university affiliated cancer centres and in one community-based teaching hospital with 624 medical oncology outpatients and 199 radiation oncology outpatients. They reported 32.1 percent of patients had weak to mild pain and 29.7 percent of patients had moderate to severe pain (Hyun et al., 2003). In another study, which was a nationwide prospective study, a

cross-sectional survey was conducted in 2001 and 2006 to assess whether cancer pain had been appropriately managed since the introduction of the CPMG. This showed that the percentage of patients who complained of pain decreased from 47.5 to 38.4 percent with a decreased mean pain intensity (3.6 in 2001 to 3.1 in 2006) (Hong et al., 2011). However, there were still 38.4 percent of cancer patients suffering from pain and 10.6 percent of cancer patients experiencing severe pain, despite the overall improvement of cancer pain management outcomes. In another study, Jung (2009) conducted a survey to provide basic information regarding cancer patients who visited an Emergency Department (ED) in a university affiliated hospital in Seoul. She reviewed nursing records, medical records and discharge summaries in the ED for 4,189 patients with cancer who visited the study setting over a 6 months period. The study presented data showing that 27 percent of those patients with cancer visited the ED with the chief complaint of 'pain' followed by 'fever (11.51%)' and 'breathing difficulty (8.69%)' and 46 percent of the patients were experiencing pain during their visit to the ED. As shown above, different studies have shown slightly different prevalence rates possibly due to different snapshots in time in the settings under study. However, it is clear that a large number of people with cancer continue to suffer with pain unnecessarily despite many advances in knowledge about pain and pain management techniques.

As mentioned above, inadequate pain management decreases the quality of life by impacting on levels of daily activities and sleep among patients with cancer. It increases the risk of medical complications associated with the use of analgesic medications, such as constipation, nausea and drowsiness resulting in refusal of treatment. Furthermore, the presence of unrelieved pain among South Korean people is thought to decrease the will to live given the failure to achieve relief (Hong et al., 2011; Hyun et al., 2003). In addition, the presence of unrelieved cancer pain could increase the burden of disease for Korea and other nations because of increasing lengths of stay in hospital and readmission rates (Brink-Huis, van Achterberg, & Schoonhoven, 2008). The relief of

cancer pain is recognised as the most significant issue in cancer care and a key area for improvement in order to enhance quality of life among the patients with cancer and their families (Choi et al., 2014) in both national and international contexts. Nurses are central to the management of pain related to cancer and like other healthcare professionals need to keep abreast of changes in practice based on the best evidence available.

1.3.2. Definition of cancer pain

A widely accepted definition of pain is

“Whatever the experiencing person says it is, existing whenever (s)he says it does” (McCaffery & Pasero, 1999, p. 17).

Further it is also accepted as

... an unpleasant sensory and emotional experience associated with actual or potential tissue damage. Pain is not just a physical sensation. It is influenced by attitudes, beliefs, personality and social factors, and can affect emotional and mental wellbeing (International Association for the Study of Pain [IASP], 2017).

These definitions emphasise the multidimensional aspects of pain and that pain is a personal experience.

In light of above definitions, the researcher adopted the definition of cancer pain in this study as *‘any pain that the patient with a diagnosis of cancer experiences including cancer-related, treatment-related and non-cancer-related pain’* (American Cancer Society [ACS], 2017).

1.3.3. Meaning of cancer pain and impact of cancer pain experiences for patients

Meanings attributed to experience significantly impact on formation of human behaviour. It is essential for healthcare professionals to understand the meanings of pain in order

to be able to help patients when managing their pain and to improve cancer pain management (Meghani & Houldin, 2007). Personal, social and cultural experiences of individuals can influence meanings of cancer pain and cancer pain experiences (Ferrell & Dean, 1995). In other words, each individual continuously makes meaning based on their personal experience, social interaction and internalisation of historic and social processes (Meghani & Houldin, 2007). Eventually, meanings influenced by culture can colour individuals' attitudes and responses to, for instance, cancer pain (Koffman, Morgan, Edmonds, Speck, & Higgingson, 2008). Given that meanings are created within relationships and interactions between the individual and society where the individual is located, it is essential to understand that different factors can have an influence on the creation of the meaning of pain in individual patients.

For example, Anderson et al. (2002) conducted a structured interview among African-American and Hispanic participants showing descriptions of pain as physical 'hurt' (73%) and 'limitations in activities and functions' (27%) among African-American respondents. Hispanic participants described pain as physical and/or emotional suffering (53%), part of disease (18%), nothing and death (12%), hurt, or to see God soon (17%). The meaning of pain can be understood through the Korean words that are used to indicate pain. 'Tongzzng (통증, pain)' in Korean equates to the experience of the 'symptom of being in pain and having a painful condition'. The words, ' Aphun (아픈, painful)' or ' Aphuda (아프다)' are used to describe a status of 'being' or 'the feeling arising because of physical, psychological and emotional issues due to injury, suffering, agony and distress or the actual symptoms of disease'. 'Pain' is considered as a multidimensional phenomenon for patients with cancer and the original meaning of the Korean words that indicate and/or relate to 'pain', cover not only physical sensory experiences but also far greater and broader experiences.

One view from reports of experience of pain suggests a 'social meaning' attached to pain and that patients prefer not to take pain relieving medications if there is minimal impact on their quality of life as a result of pain (Yates et al., 2004). This suggests that outcomes such as maintenance of levels of activity or improvements in sense of wellbeing are important from the patients' perspectives. However, when pain exceeds moderate levels, it seriously disturbs quality of life, leading to a series of physical, psychosocial and spiritual consequences. Furthermore, when severe pain is left without adequate treatment, it may become suffering which is hard to measure and triggers patients to start thinking of giving up on continuing to live, in order to take the pain away (Human Rights Watch, 2009). In the study by Anderson et al. (2002), participants who had cancer related pain emphasised changes in their lives because of pain. These were limitations of general activities and work, family and social activities and responsibilities and mood changes.

Physical pain can increase emotional pain as described in the descriptive qualitative study by Im (2006). In her study, one participant who had treatment involving a transverse rectus abdominis myocutaneous (TRAM) flap¹, described her experience. She stated that although her cancer treatment was complete and she had no more cancer, because of the TRAM flap, she was still in pain in the abdomen with sexual activity; the muscle had been removed and it caused further emotional pain. Some cancer patients claim their emotional pain is more significant than the physical. Im (2006) described another study participant isolated in a room for precautions associated with treatment and procedures. Precautions meant a lead container was used for collecting her urine following radiation treatment. No family members or friends considered the

¹ Transverse Rectus Abdominis Myocutaneous (TRAM) flap: TRAM is a muscle in the lower abdomen between the waist and the pubic bone. A flap of the skin, fat, and all or part of the underlying rectus abdominus muscle are used to reconstruct the breast in case of post mastectomy for breast cancer (Breastcancer.org, 2017).

participant as a cancer patient, because of the treatment she was receiving was neither typical chemotherapy nor traditional radiotherapy, but a type of injection that required three days isolation in a designated room. She felt the pain of loneliness during treatment and isolation in the room, and lack of acknowledgement of the seriousness of her illness by family and friends. Love and belonging are basic human needs and should be fulfilled through seriously considering psychosocial pain (Crisp & Taylor, 2005). Feelings of loss of control of the body can cause a sense of hopelessness and decreased self-esteem (Im, 2006). It has also been reported that chronic pain enhances psychological issues such as depression and anxiety four-fold (Al-Atiyyat, 2008). Dunham, Ingleton, Ryan, and Gott (2013) conducted a narrative literature review of older people with cancer pain experiences and found out that expression of pain experience among patients was contrasted with the pain assessment of healthcare professionals including nurses. Many studies in their review illustrated that those older people had a tendency of not reporting pain, because they equated increasing pain in frequency and severity as the disease progressing and eventually causing death, and believed that having extra analgesics would cause a chance of having an adverse reaction. The authors, in their narrative literature review, recommended good communication with the older patients with cancer to reduce their fear of cancer pain, but enhance the accuracy of pain assessment.

Cancer pain can be conceptualised as a multidimensional experience including physical symptoms, psychological problems, social difficulties, cultural issues and spiritual concerns which have an effect on cancer pain, and cancer pain can increase those issues (Coward & Wilkie, 2000). The literature highlights the transitional nature of the meaning of pain. When diagnosed with cancer, patients pass through different psychological and emotional stages. Most of them finally reach acceptance of the presence of pain and have new perspectives on attitudes towards life. In a cross sectional qualitative study cancer patients were grateful, became thankful, and accepted new situations, finding new meanings in their lives, when they realised their lives were

not at threat; they could tolerate pain better (Im et al., 2009). When cancer pain is well controlled, patients do not need to suffer from pain, which prevents activities of daily living (Al-Atiyyat, 2008). Thus, improving the quality of cancer pain management through enhancing the patients' ability to develop positive meanings for life despite the reality of being ill with pain can lead to improvement in quality of life and even survivorship (Ferrell & Dean, 1995; Zaza & Baine, 2002).

Understanding the meaning of cancer pain and the factors that impact on establishment of meanings for individual cancer patients is essential to provide quality care. There are some influencing factors like gender difference which are inconclusive and some factors like culture are not simple to classify or define. It is important to consider each individual and experience as unique with respect to the circumstances that influence the ways of thinking, acting and perceiving pain experiences (Im, 2006). Cho, Hong, Han, and Um (2006) identified the meaning of quality care for cancer patients by using a phenomenological approach with thirty cancer patients who were aware of their own diagnoses of cancer. Study participants identified that oncology nurses should value the fulfilment of patients' physical and psychosocial needs, be able to trust, stay positive and enhance happiness through improving physical and psychosocial well-being in order to provide quality care. They further emphasised that nurses providing care need to meet the needs of patients, while they expected them to be professional in their approaches to care. Similar findings were reported through themes in a qualitative interview study of Rustøen, Gaardsrud, Leegaard, and Wahl (2009) that was conducted to explore experiences of those patients with cancer on nursing pain management. Those themes included 'being present and supportive', 'giving information and sharing knowledge', 'taking care of medication', and 'recognising the pain'. Cancer pain, like all pain, is subjective requiring an individualised holistic approach to treatment and care. Nurses are central to the care of people with cancer. They need to manage pain as competent and informed healthcare professionals and advocate for patients and their families.

EBGs are the foundation for quality healthcare practices, as they ensure that healthcare professionals including nurses make clinical decisions for individual patients based on evidence.

1.4. Nursing Practice in Managing Cancer Pain: Evidence-Based Practice (EBP), EBGs and CPMG

Healthcare practices in South Korea have been dependent on achieving financial goals in the past however, attention to the quality of care has increased with EBP, as it considers the hallmark of positive health outcomes for patients and their families (Pooler, 2014). Regardless of the ways of implementing EBP in nursing practice including for cancer pain management, use of EBGs is considered as the main way of improving care processes and patient outcomes as it assists with better decision making among those nurses (Brink-Huis et al., 2008).

In their position statement on cancer pain management the Oncology Nursing Society (ONS, 2017) states that;

*“Cancer pain **prevention** and **culturally relevant and sensitive pain assessment, education, and management** are essential elements of **quality cancer care** throughout **all phases** of the cancer care continuum.”*

In order to achieve quality management of cancer pain, nurses must play pivotal roles as a part of the interdisciplinary team. They must be able to make critical decisions in every step of their practice. The need for evidence-based nursing practice using EBGs has increased significantly (Choi et al., 2014) and is now considered as nurses' ethical responsibility (ONS, 2017).

There are four main elements to practice that internationally recognised EBGs (Australian Adult Cancer Pain Management Guideline Working Party [AACPMGWP],

2016; National Comprehensive Cancer Network [NCCN], 2017; Ripamonti, Bandieri, & Roila, 2012) for cancer pain management and these are as follow;

- **An interprofessional and collaborative approach** through screening, assessment, intervention and evaluation to optimise patient outcomes in managing cancer pain;
- **Patient-centred care (PCC)** through providing care that reflecting patient's needs and preferences, using specific educational material to achieve informed decision-making among the patients and involving those significant (to the patient) such as family into the care process;
- **Use of evidence-based pain assessment tools with trust of patient's self-report** of pain for assessment;
- **Use of pharmacological and non-pharmacological interventions** as the standard care.

In response to the increased interest in cancer pain management among healthcare professionals including nurses and a call for more attention to the development of national guidelines (Hyun et al., 2003), the Ministry of Health and Welfare in South Korea introduced at a national level guidelines for managing cancer pain, the CPMG this was considered as an EBG (Lee, 2007). The primary objective of the policy directive and the guidelines was to provide a model of care to guide and support health professionals through improved coordination of services and early intervention strategies designed to improve the quality of cancer patients' lives by managing cancer pain early (Heo, 2007). Since the publication of the CPMG, it was announced that there were improvements in cancer pain management, especially with greater availability of opioid analgesics and the review of Health Insurance Review and Accreditation Service (HIRAS) on the use of opioid analgesic (National Cancer Center [NCC], 2011).

However, several studies in South Korea reported poorly managed cancer pain, low patients' satisfaction, and poor knowledge and attitudes towards cancer pain management (Hwang, Ryoo, & Park, 2007; Jun et al., 2006; Kim, Lee, Hwang, Yoo, & Lee, 2006; Yoo, Lee, Cho, & Lee, 2005). Two Master's degrees theses (Cho, 2009; Yu, 2011) reported that nurses who were aware of existence of the CPMG performed better pain management interventions with more knowledge than the nurses who unaware of the CPMG. However, these studies did not present how the guideline actually impacted on nurses' practice and their understanding of the concept of cancer pain management, and how it has changed nursing practice. Despite the changes that have been claimed as the impact of the CPMG through different studies in Korea, these claims may not have been as meaningful to optimal patient care experiences, if the contribution related to nursing practice is not identified and its implementation does not reflect EBP. Therefore, it is important to critically examine the impact of the uptake of the CPMG and nurses' experiences and practices associated with caring for patients with cancer pain.

1.5. Significance of the Study

Korean society is undergoing rapid change with higher expectations for improvements in the quality of healthcare (OECD, 2012). For the nursing profession, the development and implementation of the CPMG is one of the most significant changes designed to improve the care quality and patient outcomes for those patients with cancer.

As cancer pain is a unique individual patient experience (ONS, 2017) and the roles of nurses have been expanded and extended with the increasing expectation of the quality of care (Seol et al., 2017), the importance of practising based on evidence including managing cancer pain has become apparent. Implementation of the use of EBGs in nursing practice is an effective stimulus to achieving EBP in caring for patients with cancer pain and improving their quality of life (Eaton, Meins, Mitchell, Voss, &

Doorenbos, 2015). This research is the first critical examination of the impact of the introduction of the CPMG on the clinical practices of the nurses in cancer care facilities in South Korea. The study reveals details of not only nurses' use of guidelines and 'how' and 'why' they practise in the way they do, but also underpinning issues in managing cancer pain based on evidence.

The thesis provides insight for new directions for policy makers, healthcare organisations, practising nurses and patients/families. The evidence from the thesis may be used to 1) inform policy makers with further development and revision of EBGs in a systematic and practical way for healthcare professionals including nurses; 2) help organisations have a better understanding about their own roles, when they consider implementing any innovative ideas including the use of EBGs in practice to promote quality of care and optimal patient outcomes; 3) encourage healthcare professionals, particularly nurses, to engage in and improve the quality of their practice; and 4) enhance patient-family involvement in managing cancer pain.

Conclusion

This introductory chapter provides background to the research presented in this thesis. It has elaborated upon research around the topic of the impact of the introduction of the CPMG on nursing practice, particularly in the context of South Korea. An argument has been made to support the significance of the study for the nursing profession, and hence the choice of a critical theoretical stance as a research paradigm that informs the study questions.

In Chapter Two the researcher provides a review of the CPMG, its quality as the international level of EBGs and suitability for nurses' use. A critical review of the literature focuses on the current nursing practice for managing cancer pain that includes nurses' perception, knowledge about/attitudes towards/performance for cancer pain

management and their actual practice in managing cancer pain; and use of EBGs in managing cancer pain among those nurses.

Chapter Three provides discussion on the research methodology for this study, Critical Ethnography (CE) and the conceptual framework. An overview of the design and methods for the study is provided along with a description of the South Korean healthcare delivery system and the research site, and the methods and process of data collection and analysis.

The findings from the critical analysis of the data are presented in Chapter Four. It illustrates the extent of the implementation of the CPMG, the nurses' usual practice of managing cancer pain and the nurses' experience of cancer pain management.

The critical issues emerged from the findings of the study are discussed in the Chapter Five where the research questions are addressed with an in-depth discussion of the historically, politically, socially, culturally and economically ingrained influential factors for the implementation of the CPMG and nursing practice in managing cancer pain. The chapter concludes with recommendations for a more integrated approach to EBP in cancer pain management.

CHAPTER TWO

A CRITICAL REVIEW OF THE LITERATURE

Introduction

To begin this chapter, a critical review of the introduction of guidelines for practice is presented with focus on the CPMG, its quality in terms of an EBG internationally and its suitability for nurses' use. This is followed by a review of literature about the current nursing practice for managing cancer pain that includes nurses' perceptions, knowledge about/attitudes towards/performance for cancer pain management and their actual practice in managing cancer pain that illustrates the nurses' roles in managing cancer pain; and use of EBGs in managing cancer pain by those nurses.

2.1. Background

Successful dissemination of an EBG requires strategies for use and uptake by all stakeholders including nurses. The WHO report suggest that all health professionals need to be given opportunity to be involved in developing an EBG and embedding evidence into professional practice and education (WHO, 2017b). For example, dissemination of guidelines to nurses who are involved in pain management requires appropriate educational strategies to translate the guidelines into their practice (Medves et al., 2010; Powell et al., 2017). However, in reality, two studies by Cho (2009) and Yu (2011) investigated nurses' knowledge about and performance with cancer pain management. They reported that it was not clear how nursing practice was influenced by any guidelines. Van den Beuken-van Everdingen et al. (2016) also pointed out in their systematic review that despite the effort to encourage use of guidelines to improve patient outcomes around pain management, there was little evidence showing improvement in the study settings including acute settings. Baatiema et al. (2017) argue that the uptake and adoption of EBGs are often delayed or fail because of a range of barriers across organisational healthcare professional domains, patient care and policies

(guidelines). While there is some evidence about the barriers, facilitators and interventions that impact on the uptake of evidence from systematic reviews (Wallace, Byrne, & Clarke, 2014), little is known about what constitutes a high quality of guidelines and how it may impact on the uptake of guidelines. Therefore, as the first step, how the guidelines for pain management were appraised is presented.

2.2. Appraisal of Guidelines for Cancer Pain Management: International Guidelines and the CPMG

Cancer Care Ontario's Cancer-related Pain Management Guideline Panel conducted a systematic review of pain management guidelines using the Appraisal of Guideline Research and Evaluation I (AGREE I); eight guidelines of a set of twenty-five were finally evaluated (Green et al., 2010). They have developed the evidence-based and consensus recommendations for practice. Green et al. (2010, p. 452) recommended 11 elements for inclusion in cancer pain management guidelines such as *"assessment of pain; assessors of pain; time and frequency of assessment; components of pain assessment; assessment of pain in special populations; plan of care; pharmacologic intervention; non-pharmacologic intervention; documentation; education; and outcome measurement of cancer pain management"*. They emphasised patient and family centred care, customised care and an interdisciplinary team approach to provide optimal cancer pain management. Those recommended elements are also reflective of the elements that the internationally recognised EBGs should include such as interprofessional and collaborative approach, PCC, use of evidence-based assessment tool with trusting patient's self-report of pain, and the use of pharmacological and non-pharmacological interventions. The review of further international and Korean guidelines for cancer pain management were guided by those recommendations (See Appendix 2.1).

The search for 'Guideline' was conducted through the reference list of the report of Green et al. (2010), then a more extensive online search for the cancer pain management

guidelines followed. Only four guidelines were cancer pain management focused in the review of Green et al. (2010). The American Pain Society [APS]'s 'Guideline for the management of cancer pain in adults and children' was not available in the full version, because these guidelines were no longer viewed as guidance for current medical practice, and are archived (APS, 2004). Three guidelines; the 'Cancer pain management manual' (Canadian Association of Nurses in Oncology [CANO], 2004), the 'Guidelines for the management of cancer-related pain in adults' of the Cancer Care Nova Scotia [CCNS] (SupportiveCare Cancer Site Team, 2005), and the 'Control of pain in patients with cancer: a national clinical guideline' (Scottish Intercollegiate Guidelines Network [SIGN], 2008) were selected for review. The 'NCCN Clinical Practice Guidelines in Oncology: Adult Cancer Pain' (NCCN, 2017), 'Best Practice Statement: The management of pain in patients with cancer' (NHS Quality Improvement Scotland, 2009) and 'Cancer Pain Management in Adults' (AACPMGWP, 2016) were also selected and reviewed.

The AGREE II (Brouwers, Kho, Browman, Burgers, Cluzeau, Feder, Fervers, Graham, Grimshaw, et al., 2010) was used as this was the most recent version to review the quality of guidelines. The researcher endeavoured to find relevant information about each guideline development process prior to the appraisal as not every guideline included how the guideline was developed, but it was often difficult to obtain sufficient level of information to retrieve the entire process. There were times when the researcher had to skip certain items or rate the item as 1 (lower possible quality) and consider it as absence of information as instructed by the user's manual. It required at least two reviewers to individually assess and make consensus about decision for recommending each guideline. Therefore, one of the supervisors helped in appraising the quality of guidelines and the scores for each domain for individual guideline is presented in Appendix 2.2.

The CPMG was originally developed based on reviews of the WHO Cancer Pain Relief document in 2004 (Ministry of Health and Welfare [MHW], 2010). Whilst the current sixth edition CPMG for health care professionals is now in use, the fifth edition was used during the time of data collection for the research reported in this thesis. Whilst, the sixth edition of the CPMG includes a brief description of revision processes with the list of references used for its update (MHW and NCC, 2015), the fifth edition includes a brief summary of changes from previous editions without a reference list (MHW and NCC, 2012). According to Heo (2007), the initial development of the CPMG heavily relied on benchmarking the WHO Cancer Pain Relief.

Although there was no clear description of the background or the scope of the CPMG included in the introduction to the guidelines for use by healthcare professionals in South Korea, some description of the development processes and background to their use were gleaned from the literature review conducted for this study. The following is a summary of development and use of these sets of guidelines including the fifth and sixth editions:

- Issues of pain management for the patients with cancer were raised among some healthcare professional groups in South Korea in the late 1900s and early 2000s. There were few relevant and clear known causes of inadequate pain management for this patient group such as very low rate of opioid-analgesic use, inadequate patient self-reporting or a lack of attention among the healthcare professionals (Hong et al., 2011).
- The Korean Society for Hospice and Palliative Care and the Korean Cancer Study Group initiated the development of guidelines for cancer pain management to achieve the following purposes: 1) to propose a consensus on managing the needs of those people with cancer pain; 2) to establish an institutionalised foundation for effective cancer pain management; and 3) to initiate systematic research for evidence on approaches to more effective pain management (Heo, 2007).

- The Korean Society of Nursing Science and the Korean Oncology Nursing Society were the only two nursing 'academy groups' among 25 groups that participated in developing the CPMG (MHW and NCC, 2012).

Based on recommendations of Green et al. (2010), selected guidelines have been reviewed for appropriate content (See Appendix 2.1). The content of the CPMG included: 1) Introduction (intentions, need for guidelines, prevalence and classification of pain/causes of pain); 2) pain assessment (elements of basic assessment – PQRST (Position, quality, relieving or aggravating factors, severity and timing), history, psychological issues, misconceptions on pain and pain management, assessment tools, ongoing pain evaluation; 3) pain management (general principles of multidisciplinary approaches and family education/consultation; principles of use of pharmacological interventions; non-opioid/opioid analgesics including a flow chart to assist with making decision for using analgesics, equi-analgesic dose table, management of adverse effects, available opioid analgesic list; and adjuvant analgesics); 4) cancer pain management for children; 5) radiotherapy for cancer pain; 6) nerve blocking for cancer pain management; and 7) treatment for intractable cancer pain.

Clear statements of the scope and the purposes of the guidelines are essential. They include the overall aim, which determines the goal of the nursing care; specific health topics, pain management for the patients with cancer; and the target population for whom the guidelines are to be used. This should prompt the nurses to consider the special circumstances of this particular group of patients (Brouwers, Kho, Browman, Burgers, Cluzeau, Feder, Fervers, Graham, Hanna, et al., 2010). The CPMG did not have distinctive statements presenting the scope and/or the purposes of the guidelines, but the brief introduction to the CPMG included the presentation of the purpose. The 25 groups involved in developing the CPMG were listed at the back of the guidelines such as the Korean Academy of Family Medicine, the Korean Association of Internal Medicine,

the Korean Society for Radiation Oncology, and the Korean Society of Gynaecology Oncology. Whilst there were several medical academic associations/societies, only two nursing academic associations/societies and a multidisciplinary academic society were involved in developing and updating the CPMG (MHW & NCC2012).

There was little evidence of how the set of guidelines was developed and updated, hence it did not give adequate explanation about how each recommendation in the guideline was made. Moreover, the guidelines were clearly medically focused. Although, the guidelines stated the range of healthcare professionals as the intended users, it subsequently appeared to limit the intended users to the medical officers (MOs) through the explanation of the processes of managing pain. For example, a statement specified *'Doctors need to educate patients/family to use the pain scale even at home in order to achieve effective pain management at home'* at the beginning part of pain assessment. This contrasted with the statement in the introduction that indicated the intended target as all healthcare professionals. Given that most of the academic associations/societies who participated the development/update of the CPMG was the medical group, it could be natural that the descriptions of the statement were medically focused.

The guidelines also highlighted important elements that were recommended as a part of cancer pain management strategies, but most of the recommended interventions needed MOs' authority in making decision on the use of the interventions and there were limited interventions recommended that nurses can use independently. Even the interventions that were identified as non-pharmacological interventions were not necessarily interventions that did not include the need for use of drugs, but were more likely the processes that needed MOs for implementation. For example, the recommended non-pharmacological interventions included radiation therapies, various nerve blocks and patient controlled analgesia (PCA) (MHW and NCC, 2012). There was a brief list of complementary/alternative therapies that could be used to help alleviate pain and

enhance the pain management outcomes. There were no detailed instructions or guidelines on how each of the suggested complementary/ alternative therapy approach such as massage, relaxation therapy and guided imagery should be provided. This is likely to have restricted other healthcare professionals from becoming engaged in cancer pain practices and it reinforced the tendency for the CPMG to be used by MOs and for cancer pain management to be seen as medically driven. Moreover, the guidelines did not provide the facilitators and barriers to their application, which would be important when considering dissemination processes.

According to Heo (2007), the development of the CPMG led to significant changes in pain management in the Korean healthcare system with descriptions of types of pain and the use of opioid analgesics, and guidelines for access to medical care benefits and how to distribute the details of the CPMG in the field. However, compared with other international guidelines such as 'Cancer Pain Management in Adult' (AACPMGWP, 2016), the CPMG fifth edition was focused on MOs' perspectives and lacks in-depth information on some important elements such as non-pharmacological interventions for pain, including psychosocial support and complementary therapies, and directions for patient/family education that can be initiated by other healthcare professionals including nurses. The CCNS guidelines (SupportiveCare Cancer Site Team, 2005) noted that guidelines should be able to support all healthcare professionals including nurses working in a variety of settings with their decision making; and they should contain a certain level of recommended evidence based information about a range of issues in cancer pain management. Despite announcements of improvements in practices since the publication of the first edition of the CPMG (Lee & Ahn, 2008), there needs to be a comprehensive review of 'what is happening' and 'what matters' in current nursing practice for cancer pain management given the identification of this gap.

2.3. Literature Review: Nursing Practice in Managing Pain among Patients with Cancer

The review of the literature aimed to examine nursing practice in managing pain for patients with cancer and was guided by the integrative review method by Whittemore and Knafl (2005) which includes five stages; problem identification (as above), literature search, data evaluation, data analysis and presentation. This integrative approach allowed the researcher to gain a more comprehensive understanding of particular healthcare issues such as cancer pain management nursing practice through summarising and synthesising the existing literature (Hopia, Latvala, & Liimatainen, 2016; Whittemore & Knafl, 2005).

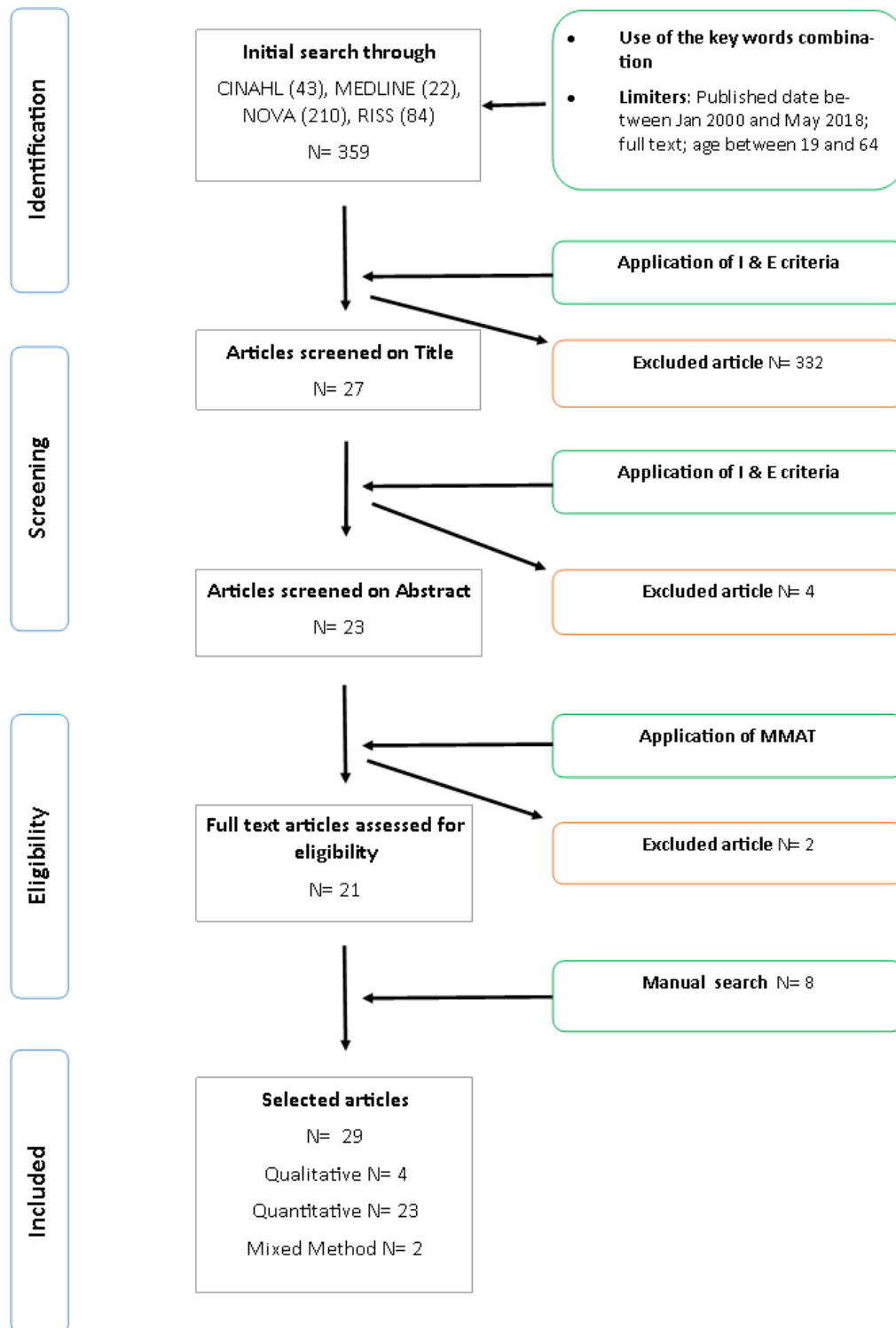
2.3.1. Literature search and selection process

Guided by the research questions for this study, Korean and international literature data bases were searched through different search engines. Figure 2.1 illustrates the search results and selection process. The Research and Information Sharing Service (RISS)², the Ministry of Education supported research institute website in South Korea, the CINAHL Complete and MEDLINE, which broadly cover the nursing related articles, and NOVA, the University of Newcastle Research Repository Online systems were used with the combination of the key words as follows

- ‘nurse (nursing) practice (간호) + (evidence based) guidelines ((근거중심) 가이드라인)
+ cancer pain management (암성통증 관리)’

² Research and Information Sharing Service (RISS) is the official website for sharing data that is owned and subscribed to by all Korean tertiary education sectors. Therefore, it provides the access for national and international theses and dissertations, journal articles, major academic database and open lecture materials.

Figure 2.1. Literature Search and Selection Process



- 'nursing practice (간호) + cancer pain management (암성통증 관리) + (acute setting) (병원)'

- ‘nurses (간호사) + experiences (경험) + cancer pain management (암성통증관리)’
- ‘nurses (간호사) + roles (functions) (역할 (기능)) + cancer pain management (암성통증관리)’
- ‘nurses (간호사) + cancer pain management (암성통증관리) + facilitators/barriers (촉진요인/장애요인)’

Published date between January 2000 and May 2018; full text; and age groups between 19 and 64 were applied as search limits. The search was limited to theses (dissertations) for masters or doctoral degrees and published articles; this led to 359 articles for further review. After application of inclusion/exclusion criteria (see Tab 2.1) on two different levels (on title and abstract of each article), 23 articles remained.

Table 2.1. Inclusion & Exclusion Criteria for Literature Search

| Inclusion Criteria | Exclusion Criteria |
|---|---|
| - Original research (Quantitative, qualitative and/or mixed method studies) | - All editorials, review based articles and protocols |
| - Cancer pain focused | - Non-cancer pain focused |
| - Major participants as RNs | - Major participants as patients/family or other healthcare professionals rather than RNs |
| - General nursing practice for cancer pain management | - Outcome measurement of certain interventions, programs and/or education focused |
| - Acute inpatient setting focused | - Outpatient, palliative and/or aged care facility setting focused |
| - Adult nursing focused | - Paediatric nursing focused |
| | - Duplicated and/or unable to access full text |

2.3.2. Evaluation of the literature identified

According to Whitemore and Knafl (2005), there is no gold standard for assessing methodological quality. The methodological quality was assessed by using the Mixed Methods Appraisal Tool (MMAT) developed by Magill University (Pluye et al., 2011). The MMAT allowed the researcher to appraise each study's quality against the assessment criteria and convert results into a total score of 100 per cent. The MMAT appraises the methodological quality of the study, not the quality of report writing (Pluye, Gagnon, Griffiths, & Johnson-Lafleur, 2009). The scores for selected study for review are included in Appendix 2.3.

After the application of the MMAT (Pluye et al., 2011) to assess the quality of each article with the inclusion criteria of the MMAT score of 50 percent and over, 21 articles were selected for the literature review. A manual search of individual journals with the application of the same selection criteria added 8 more articles, therefore a total of 29 articles was used for the integrative review (See Appendix 2.3).

2.3.3. Analysis and synthesis of the literature

The identified articles were analysed using thematic analysis by Braun and Clarke's (2006) guide to conducting thematic analysis. The issues identified from the selected articles were classified into categories; 1) nurses' perception related (Al Khalaileh & Al Qadire, 2012; Byun & Choi, 2013; De Silva & Rolls, 2011; Garcia, Whitehead, & Winter, 2015; LeBaron, Beck, Black, & Palat, 2014; LeBaron, Beck, Maurer, Black, & Palat, 2014; Yoo et al., 2005); 2) interlinked nurses' knowledge about/attitudes towards pain and/or pain management, and/or performance for managing pain (Alqahtani & Jones, 2015; Bernardi, Catania, & Tridello, 2007; Cho, 2009; Hollen, Hollen, & Stolte, 2000; Hwang, 2006; Jang, 2015; Kim, 2004; Kim, 2014; Kim, Park, & Kang, 2012; Kim, 2008; Kim &

Park, 2012; Kwon, 2009; McMillan, Tittle, Hagan, Laughlin, & Tabler, 2000; Mun, 2014; Nam, 2003; Park, 2012b; Park, 2013a; Song & Kim, 2010; Yildirim, Fadiloglu, & Meltem, 2008; Yu, 2011); and 3) EBP in managing cancer pain among nurses (Eaton et al., 2015; Eaton, Meins, Zeliadt, & Doorenbos, 2017).

2.3.4. The findings from the literature

2.3.4.1. Nurses' perceptions on cancer pain and its management

Nurses' perceptions on cancer pain and its management are believed to be significant influential factors on their nursing practice in managing cancer pain (Gordon et al., 2005; Max et al., 1995). This view was clearly presented in several studies showing nurses' misperception and/or negative perception towards cancer pain and/or its management prevented nurses' optimum care for those patients with cancer (Al Khalaileh & Al Qadire, 2012; Garcia et al., 2015; LeBaron, Beck, Maurer, et al., 2014). In a study by Garcia et al. (2015) five registered nurses were interviewed using a semi-structured interview method to explore how they perceived pain among the patients with cancer. The nurses reported cancer pain as an individual experience that was complex and difficult to manage, and something that could cause emotional and psychological distress such as frustration and helplessness. Nurses appeared to recognise the multidimensional characteristics of pain and pain as individual experiences. However, it was common for nurses to have different perceptions, often contrary, to the patients' perceptions about pain. Byun and Choi (2013) emphasised a significant discrepancy between patients and nurses when they measured the patients' experience of pain in their study to compare the levels of pain intensity and pain relief with 90 patients and 90 nurses. The patients reported 6.59 out of 10 as the most severe pain, while the nurses recorded 3.98 in their nursing record. Also, the nurses recorded 1.67 on the first day as the most significant pain relief, whilst the patients reported 2.87 on the third day of given interventions.

Nurses' misconceptions of patients' actual experience of pain – both over-reporting of pain and underestimating pain have resulted in poor decision making on pain management, particularly in the use of analgesics including opioids (Al Khalaileh & Al Qadire, 2012; LeBaron, Beck, Maurer, et al., 2014; Yoo et al., 2005). The nurses in the studies reported misperceptions of harmful and physiological effects of analgesics, and fear of addiction, for example, they believed that the use of pain medicine blocked ability to know if patients developed new pain' (Al Khalaileh & Al Qadire, 2012; Yoo et al., 2005). However, the nurses described frustration and helplessness, when they could not provide optimum pain relief (De Silva & Rolls, 2011; Garcia et al., 2015; LeBaron, Beck, Black, et al., 2014).

2.3.4.2. Interlinked knowledge about/attitudes towards/performance of cancer pain management

The review of literature revealed that one of the major areas of nursing research around cancer pain was nurses' knowledge about cancer pain management. There were 19 articles on that which illustrated; 1) assessment of nurses' knowledge about (Kim, 2008; Park, 2013a; Song & Kim, 2010); 2) knowledge about and perceptions towards (Kim et al., 2012); 3) knowledge about and attitudes towards (Alqahtani & Jones, 2015; Bernardi et al., 2007; Hollen et al., 2000; Kim, 2004; Kim & Park, 2012; Kwon, 2009; McMillan et al., 2000; Nam, 2003; Park, 2012b; Yildirim et al., 2008); and 4) knowledge about and performance for cancer pain and its management (Cho, 2009; Hwang, 2006; Jang, 2015; Kim, 2014; Mun, 2014; Yu, 2011).

Although some studies reported some improvement in knowledge among nurses regarding cancer pain management (Jang, 2015; Park, 2012b), others revealed nurses' lack of knowledge, which was often accompanied with poor attitudes (Alqahtani & Jones, 2015; Bernardi et al., 2007; Hwang, 2006; Kim, 2004; Nam, 2003; Park, 2013a). Also, in South Korea Song and Kim (2010) in their descriptive study to explore the potential

factors in relation to nurses' management of cancer pain, found that nurses had lacked knowledge on analgesia, assessment, non-pharmacologic intervention, and competency especially in the use of PRN analgesics. They described situations in which the nurses provided PRN drugs after they had double checked orders with MOs, which indicated a lack of competence in making decisions and a lack of trust between nurses and MOs.

A lack of knowledge regarding cancer pain assessment and management among nurses providing care for cancer patients with pain is considered a major barrier to appropriate care (Kim et al., 2012). Lack of knowledge among nurses results in poor assessments, increases anxiety about regulation of controlled drugs and encourages concerns about the adverse effects and addiction to/tolerance of analgesics. Nurses who had inadequate knowledge had misconceptions about patients' over-reporting of pain and underestimating pain, with subsequently poor decision making, and poor communication with healthcare professionals and cancer patients (Yildirim et al., 2008). The positive relationship between nurses' knowledge about the cancer pain and their level of performance in caring those patients with cancer is well reported in other studies (Cho, 2009; Hwang, 2006; Jang, 2015; Mun, 2014; Yu, 2011). In other words, a lack of knowledge eventually leads to poor attitudes towards cancer pain management and poor performance.

Poor attitudes towards pain are significant barriers in optimising cancer pain management. Despite the fact that the patient's account of pain should be believed and this should be the starting point of cancer pain management, nurses tend to make judgements which over-ride the patient's verbal expressions of pain experiences (Cancer-related Pain Management Working Panel, 2012). For example, in a study conducted by Yoo et al. (2005), they compared the levels of barriers between patients (n=155) and their nurses (n=153) in pain management of metastatic or advanced cancer. They found that nurses managed patients' cancer pain based on their assumption and

judgement rather than what the patient expressed. The authors suggested that nurses' ignorance of pain was due to a lack of understanding of how patients feel when they are in pain.

For the above reasons, the literature reviewed suggests that adequate education be provided to nurses in the provision of cancer pain management strategies for the patients with cancer, and that educational interventions played a significant role and effectiveness in improving nursing knowledge and attitudes (Yildirim, Cicek, & Uyar, 2009). However, developing quality education program and delivery methods should be considered as fundamental elements. Green et al. (2010) recommended that the education should include clarifying misconceptions about cancer pain management among cancer patients and their care givers and health care professionals including nurses, and principles of cancer pain management. It is often reported that effectiveness of non-consecutive education is less long lasting; providing ongoing education is essential to improve and maintain the effectiveness of education (Bennett, Flemming, & Closs, 2011).

2.3.4.3. Evidence-based nursing practice for cancer pain management

Two mixed method studies presented nurses' beliefs and behaviours on the use of EBP and exploring influential factors for using EBP in their practice in managing cancer pain (Eaton et al., 2015; Eaton et al., 2017). Eaton et al. (2015) stated that nurses (n=40) in the studies supported the positive aspect of EBP in their practice in managing cancer pain, but their use of evidence as a basis for practice was still minimal. Eaton et al. (2017) then illustrated influential factors including organisational factors such as nursing documents and inadequate resource supports from the organisations, and lack of nursing leaders who could be the role model of providing EBP in managing cancer pain. Eaton et al. (2015) found that EBP in cancer pain management decision making was unclear and identification of evidence-based pain management practice was limited.

These authors highlighted the need for the development of EBGs to implement EBP in nursing practice in order to provide care that has greater potential for a positive impact.

Developing guidelines in a systematic way, based on evidence would be a fundamental step of establishing EBGs in nursing practice for cancer pain management. Although there are a number of quality EBGs for cancer pain management that can be used by nurses which are developed and based on evidence (AACPMGWP, 2016; CANO, 2004; SIGN, 2008), consistent adoption of EBGs into nursing practice appears to be suboptimal, despite its potential benefits (Dulko, Hertz, Julien, Beck, & Mooney, 2010). There is only a limited number of studies published in relation to the use of cancer pain management EBGs and their impact on nursing practice.

There was no study that illustrated how the CPMG was used as EBGs and how it impacted on nursing practice and patient outcomes in terms of managing pain. Some studies used the CPMG as the reference point in order to develop surveys for their studies and found the nurses who were aware of existence of the CPMG had better knowledge, attitudes and/or performance in managing pain among those patients with cancer (Cho, 2009; Jang, 2015; Kim, 2014; Yu, 2011). However, the result did not provide details on whether the CPMG was actually used in the study settings as EBGs among nurses after its introduction, and whether it influenced the making of any positive changes in the current nursing practice in South Korean healthcare settings.

Conclusion

Given the increase in prevalence of cancer, prevalence rates of cancer pain, and the importance of cancer care, especially the management of pain, there is the need for better management of the patient experience. In this chapter, a critical review of the literature relevant to the research topic was conducted.

The fact that little is known about what constitutes a high quality of guidelines and how this may impact on the uptake of guidelines has led to the appraisal of how the guidelines for pain management were evaluated. The critical appraisal of guidelines using Green et al.'s 11 elements for evidence-based recommendations for cancer pain management highlighted, despite announcements of improvements in practices since the publication of the first edition of the CPMG (Lee & Ahn, 2008), that there needs to be a comprehensive review of '*what is happening*' and '*what matters*' in current nursing practice for cancer pain management.

An integrative review guided by the framework of Whitemore and Knafl (2005) was conducted to examine nursing practice in managing pain for patients with cancer. The key issues identified include; 1) nurses' misconceptions of patients' actual experience of pain – both over-reporting of pain and underestimating pain have resulted in poor decision making on pain management, particularly in the use of analgesics including opioids; 2) nurses' knowledge about/attitudes towards pain and/or pain management, and/or performance for managing pain are interlinked, which means that a lack of knowledge eventually leads to poor attitudes towards cancer pain management and poor performance; and 3) there was no study that illustrated how the CPMG was used as EBGs and how it impacted on nursing practice and patient outcomes in terms of managing pain.

Given the literature review above, the impact of EBP on quality improvement and changes in practice needs to be further interrogated. For these reasons, the following chapter presents how this research enables the researcher to investigate the issues raised above and details of the purpose of the study, the development of research questions, the choice of research design and the conceptual model for data analysis that will be used within the study plan.

CHAPTER THREE

METHODOLOGY, DESIGN AND METHODS

Introduction

“Critical Ethnography (CE) begins with an ethical responsibility to address processes of unfairness or injustice within a particular lived domain... based on moral principles of human freedom and well-being, and hence a compassion for the suffering of living beings ... the critical ethnographer resists domestication and moves from “what is” to “what could be” (Madison, 2012, p. 5).

The researcher, from her own professional experience and the findings within the literature review, assumed that there are differences in patients’ and healthcare professionals’ knowledge of the disease processes around cancer pain. It was also recognised that patients can feel powerless and vulnerable in any health care setting where they have to rely on healthcare professionals and that nurses, in their own practice, can be seen as a privileged group having power over patients (Street, 1992). At the same time nurses themselves can be seen as the oppressed group given their position when influenced by other health professionals with more formal power such as doctors. With this in mind, the study was underpinned by an enquiry approach as to how elements of a policy around a set of guidelines was embedded and how positive evidence-based changes could be brought into the culture, context and the nurses’ and patients’ experiences of cancer care and pain management.

CE allowed the researcher to observe practice, explore reports on experiences and critically examine the emergent themes from the storylines provided by the nurse participants in this study.

3.1. The Aims of the Study

As stated in Chapter One, the aims of this study were to:

- 1) Critically explore the impact of the introduction of the CPMG on clinical practice of the nurses in cancer care facilities.
- 2) Uncover the roles and functions of nurses and the factors that influenced or hindered the adoption/spread/uptake of the CPMG.

3.2. The Research Questions

The research questions asked:

What is the impact of the introduction of the Cancer Pain Management Guideline on nursing practice in South Korea healthcare context?

In particular

- a. *How do nurses provide care for the cancer patients who are experiencing pain in one acute healthcare setting in South Korea?*
- b. *What do nurses do in their practice of pain management?*
- c. *What policies, procedures and guidelines are used in cancer pain practice?*
- d. *What are the experiences of nurses in relation to cancer pain management?*
- e. *Is practice consistent (or inconsistent) with evidence-based international guidelines for cancer pain management? In what ways is this so?*
- f. *What are the facilitators and barriers to the uptake of the CPMG in Korea?*
- g. *What are the barriers to cancer pain management and the use of the evidence-based guidelines?*
- h. *What are the facilitators to cancer pain management and use of the evidence-based guidelines?*

In the light of the aims and the research questions CE was deemed the most appropriate methodology for the study. CE allowed the researcher to observe practice, explore reports on experiences and critically examine the emergent themes from the storylines provided by the 10 nurse participants in this study.

Given an assumption of the likelihood of observations and reports of power imbalances between those receiving cancer-related care and those providing care and among the providers of care, the researcher adopted a critical stance to explore the perspectives and practices of nurses around the translation of evidence into policy and practice. Critical Theories were explored with a particular focus on relevance to the context of the study and the experiences of nurses.

3.3. Critical Theory (CT)

3.3.1. History and tenets of CT

CT has a long history of application to nursing research (Cody, 1998; Mosqueda-Díaz, Vílchez-Barboza, Valenzuela-Suazo, & Sanhueza-Alvarado, 2014). CT was developed in the Frankfurt School in Germany in the 1920s that was supported by a Marxist philosophical base, which claimed for the need for a critical stance when appraising opposing views in particular contexts (Mosqueda-Díaz et al., 2014). In fact, CT may not be defined as having a universal form, but there are some shared assumptions (Kincheloe, McLaren, & Steinberg, 2011). The tenets of CT are that;

- 1) power relations are constituted by social and historical process and are fundamental mediators of all thoughts;
- 2) facts cannot be free from values, this means the principle of value-free objectivity cannot be achieved in research;
- 3) language is the centre of understanding among members of the society;

- 4) certain people are privileged over others, often due to the force of contemporary societies, especially as the oppressed people accept the situation as necessary, unavoidable and/or natural;
- 5) oppression can be expressed in many ways; and
- 6) the criticalist aims to achieve positive changes towards the direction of freedom and justice in societies through emancipation of those oppressed by empowering them (Kincheloe et al., 2011; Mosqueda-Díaz et al., 2014).

Each of the tenets outlined above has relevance to nursing practice where patients have experienced life-threatening diseases such as cancer. Differences in patients' and healthcare professionals' knowledge of the disease processes, patients can lead to a sense of powerlessness, and vulnerability of any or all stakeholders involves with the uptake and implementation of guidelines to practice. With this in mind, interpretation of the data included a critical stance on enquiry about 'what is evident' in actual practice settings reliant on guidelines to inform practice.

3.3.2. Power/knowledge

Around the development and use of guidelines informing health service and practice, it was noted that successful uptake of EBGs demands the involvement of all stakeholders (Florian, Kerstin, Kristina, Wolfgang, & Alexander, 2016). The use of a theoretical perspective such as Foucault's (Foucault, 1980) on the relationship between power and knowledge for the patients, the professionals providing care and the broader organisation, is useful for example around examination of the nature and extent of the uptake of EBGs. Interrogation of critical theories can contribute to better understanding of nursing practice in a healthcare system in terms of appreciating how nurses generate their knowledge of caring for patients with cancer pain issues.

Foucault is one theorist who influenced the examination of power imbalanced rationality that appears in the everyday life of the professions including nursing (Cody, 1998). Foucault focuses on analysing and interpreting the relationships among power, knowledge and the population at large; he emphasises that knowledge is produced through constant alteration of power at the 'micro' level (Bradbury-Jones, Sambrook, & Irvine, 2008; Henderson, 1994). This leads to an understanding of how 'truth' around for example the uptake of evidence informed practice is always contextual, interpreted and generated by the members of society (Hardin, 2001).

Power is generated through the interrelationships among individuals, rather than being given or taken away by the organisation; and thus it is not necessarily an element of hierarchical structure (Kuokkanen & Leino-Kilpi, 2000). In the study of Fackler, Chambers, and Bourbonniere (2015), nurses use their power through the virtual use of their specialised knowledge during the practice. Power can be conceived as an interactive network of shifting perspectives, reactions and behaviours, which can be productive, ubiquitous and dynamic, impacting changing relations among persons, groups and organisations (Taylor, 2014). It is obvious that power dynamics are observed at all different levels and are everywhere in the society as this is a feature of the nature of human beings in their relationships with others (Bradbury-Jones et al., 2008; Cheek & Porter, 1997; Davidson, 2015; Kuokkanen & Leino-Kilpi, 2000).

The power relationship can be negative and cause oppression, but it also can be positive and the reverse of oppressive situations (Davidson, 2015; Foucault, 1980; Holmes & Gastaldo, 2002). Therefore, power can be exercised by manipulation of thoughts, attitudes and social relationships with consideration of the consciousness of basic human desire and attitudes rather than a focus on action, domination and control (Kuokkanen & Leino-Kilpi, 2000). By recognising power/knowledge bases, which generates and

maintains the current patterns of dominance of scientific/medical discourse in healthcare, there is the possibility of positive change. Unchallenged, taken-for-granted assumptions about nursing practice can be offered in many instances of patient care (Cheek & Porter, 1997).

3.3.3. Disciplinary power

Hardin (2001) suggests that nursing as a discipline, consists of a docile body of healthcare professionals that carry out useful action as standardised behaviour. Every individual nurse is taking actions through and within webs of power, which are part of their everyday life and lead them to have systems of self-regulation and discipline within themselves and their behaviours (Hardin, 2001). Hierarchical observations by others within their own discipline, normalising judgement about them as a group and the examination of their actions ensures that the nurses remain disciplined, and thus they are the processes through which disciplinary power is practised (Foucault, 1995; Gilbert, 1995).

Hierarchical observation of practice can include any means of observation that coerces nurses towards particular practices. For example, this might include a nurse educator (NE) or a senior nurse's observations of new graduate nurses' endeavours and a colleague's observations of their peers that can prevent malpractice. Constant observation can increase self-consciousness about choices in care processes and eventually change patterns of behaviour among nurses.

Within patterns of hierarchical observation, 'normalising judgement' is used in the nursing discipline, that is, acceptance of being judged and compared with particular norms (Bradbury-Jones et al., 2008). Nurses can be judged by others including other nurses using the normative standards of the culture, but also the nurses may judge themselves

against the normative standards that the society holds as reasonable for that group. Such judgement and self-monitoring may improve nursing practice by achieving positive outcomes, but it also can lead to inappropriateness and inequity for both patient care and nursing practice if actions are not reflective of optimal standards. Foucault emphasises that it can be dangerous to accept anything as natural, necessary and unavoidable without critique, because it can result in power relations that are placed in static states of domination with limited validity and acceptance of thought and behaviour (Taylor, 2014).

The development and use of guidelines, such as those at the centre of this study, is intended to establish, retain and regulate competence and continuing quality of nursing practice by causing nurses to undertake ongoing examination of their practice (Bradbury-Jones et al., 2008). Creating a culture of continuous improvement and acceptance of experiences involving scrutiny (using guidelines for optimal practice) can unite the processes within hierarchical observation and supervision including judgement, which becomes 'normalised'. Therefore, disciplinary scrutiny, such as the scrutiny within nursing can be practised as a positive means of improving practice, if it is used sensitively and constructively.

The nurses in this study and their experiences are situated in the context where the power and knowledge of the members of the society are embedded; how and to what extent they critique, challenge or maintain their practice since the introduction of the CPMG within the culture of South Korea is the interest of this study. The elements of culture, context and experience are key elements of the ethnographic component of the methodology in the present study.

3.4. Critical Ethnography (CE)

CE can be defined as a qualitative approach that can describe the social and cultural practice of groups of people aiming to change the system of power relationship (Thomas, 1993). Critical ethnographers identify aspects and meanings of a group's culture such as their values, behaviours and beliefs and examine the culture through the lens of power, privilege and authority through the exercise of their ethical responsibilities to reveal inequity and unfairness; and endeavour to aim for positive changes in the group (Harrowing, Mill, Spiers, Kulig, & Kipp, 2010).

CE can be identified as a research methodology that derived from the ethnographic tradition (Baumbusch, 2010), which itself focuses on people's daily activities in the natural social settings or fields. It requires unstructured, flexible and open-ended methods for data collection (Brewer, 2000). Ethnographers study culture, the group patterns of behaviour and beliefs in order to speak for the subjects by describing and interpreting it (Thomas, 1993). These ethnographers participate in people's daily activities with or without them knowing. By observing their behaviours, listening to their conversations and asking them questions that are related to the research, the researchers set out to understand human actions and behaviour and its relationship to their circumstances (Hammersley & Atkinson, 1995). It is believed that the idea of having in-depth understanding enables explanation of the social meaning of language and behaviour which adds to knowledge (Holloway & Todres, 2010).

Through the use of ethnography, it can be possible for an outsider to gain the view of an insider on a certain phenomenon and the rules that form the behaviour and beliefs of the group; thus the researcher can describe and interpret what s/he studies (Ross, Rogers, & Duff, 2016). However, the traditional ethnographers believe that it is not possible for researchers to be free from norms and other biases, but that such things should be repressed (Thomas, 1993). Therefore, the conventional ethnographer is criticised given

that they do not focus on challenging or seeking alternative options to address issues raised through the research or to change them (Allen, Chapman, Francis, & O'Conner, 2008; Madison, 2012).

CE on the other hand, not only aims to describe and interpret the culture of, or the cultures, but it also aims to socially transform (Baumbusch, 2010). The field of nursing care is believed to be culturally unconscious, routinized and often full of thoughts and actions which are taken-for-granted; it is very easy to ignore the significant phenomena in nursing practice (Ross et al., 2016). The critical elements of the CE are opposite to the systematic, universal knowledge that has been established and influences the daily life of people uncritically, possibly causing inequity, oppression or marginalisation in certain groups, often even with no recognition of being oppressed (Carspecken, 1996). Critical ethnographers investigate other possibilities by analysing hidden agendas and 'taken-for-granted' assumptions to change power imbalances that lead to inequitable power relations (Madison, 2012).

CE seeks to understand

- the way in which people construct meaning by exploring and questioning common understandings and assumptions and
- from observations and questioning, their understanding of their own behaviour in their particular setting (Madison, 2012)

It is essential to collect the data in natural settings by spending time at the setting in a different time frame in order to collect reflective data of the nursing care (Baumbusch, 2010). The researcher can participate in different activities including following nurses to see aspects of their practice, staff meetings and patient education sessions as a participant or an observer (LeCompte, 1999). The researcher continuously maintains a

process of critical reflection to produce meaningful textual ethnographic accounts (Parissopoulos, 2014).

It is critical to note some weaknesses of CE. Although separating researcher's and participants' views is emphasised to minimise researchers' biases, it is not always easy for the researcher to critique participants' views without imposing some of the researcher's biases (Manias & Street, 2001). Another limitation is that it is often hard to implement the recommendations that derive from thick descriptions of phenomena/issues into practice. Even though CE aims to change current situations, given the existence of power relations, this is complex in reality (Vandenberg & Hall, 2011).

Nevertheless, it is believed that CE is the most appropriate methodology for the study, because it enabled the researcher to describe and interpret the findings and critically analyse them to raise critical consciousness about usual nursing practice and include consideration of the notions of both objectivity and subjectivity (Allen et al., 2008; Batch & Windsor, 2014; Madison, 2012; Vandenberg & Hall, 2011). Because the study examines the impact of the introduction of the CPMG, an innovation, on nursing practice, CE ensured the researcher has in-depth understanding of how the nurses constructed their understanding about the use of the CPMG. CE also helped to reveal how the nurses perceived their roles and functions in the healthcare setting since the introduction of the CPMG and the concomitant political, social and material impact on nurses, and how the healthcare setting, as an organisation, influenced the adoption of the CPMG in nursing practice. According to Speziale and Carpenter (2007), ethnography is a study of interaction among people, activities at the site, and the critical inquiry ensures rational analysis and changes in unjust and irrational social activities (Carspecken, 1996; Vandenberg & Hall, 2011).

In this particular study, nursing units where nurses provide care to manage pain for those cancer patients can be conceptualised as a field with its own culture, because individual nurses may have similar dispositions through exposing, experiencing and adopting the actions and practice that have been perceived as successful (Lauzon Clabo, 2008). Hence those nurses form small groups, where the researcher can conduct research given the construction of meanings of political and historical value (Batch & Windsor, 2014). Nurses' care for their patients with cancer who are experiencing pain requires the nurses to think and act in meaningful ways within the variety of their clinical nursing practice, this has to be open to scrutiny in order to disclose their habitual actions (Street, 1992).

Allen et al. (2008) emphasise that it is valuable to consider the emic and etic perspectives as the researcher explored the meaning of the collected data. This meant that the researcher should look through both insider's and outsider's viewpoint. This ensures the researcher conducts a comprehensive study of general and particular features of nursing practice; it enables the researcher to focus on a specific issue, that is, the nursing practice for cancer pain management.

CE enables the researcher to describe and critically analyse the current state of cancer pain management and the nursing practices in South Korean context and *"... opens to scrutiny otherwise hidden agendas, power centres [sic], and assumptions that inhibit, repress, and constrain"* (Thomas, 1993, p. 3).

CE is considered as 'performing' CT (Madison, 2012), which seeks the means for 'human emancipation' in circumstances of domination and oppression rather than for an achievement of some independent goal, and the theory itself is adequate only when it fulfils the criteria of being explanatory, practical and normative (Stanford Encyclopedia of Philosophy, 2005).

3.5. Study Assumptions

As noted previously, since the introduction of the CPMG for Health Care Professionals which was pursued by the Korean Society of Hospice and Palliative Care and the Korean Cancer Study Group in 2004 by the MHW in South Korea (Hong et al., 2011), the CPMG was promoted for use through the different channels including in one of the Korean Oncology Nursing Society conferences. It occurred to the researcher at the time that the effects of these changes on cancer care nurses, who were traditionally physician-dependent and task-focused would challenge the way cancer care was managed by nurses (Son, 2007).

As the researcher had experience of working in the Korean healthcare setting, and in consideration of the fact that Korean society including the healthcare system was a fast adopter of new things, the researcher believed that there must be some evidence of changes in nursing practice for cancer pain management since the introduction of the CPMG. The researcher again considered her assumptions before the commencement of this study.

- Nurses would have been informed for the publication of the CPMG, thus aware of its existence.
- Not all, but some nurses would have used the CPMG in their nursing practice in some level and it would have helped them to perform better in their roles and functions.
- There would have been some barriers to prevent the nurses to use the CPMG for their practice.
- There would be some level of evidence of adoption of the elements of the CPMG by nurses in the study setting.

3.6. Conceptual Framework

In addition to using a CE approach to analysing the data, the framework of Greenhalgh, Robert, and Bate (2008), 'A Conceptual Model for the Spread and Sustainability of Innovations in Service Delivery and Organisation' helped focusing the inquiry on relevant concepts relating to the study aims of critically analysing the nurses' clinical practice and their roles, and influential factors in cancer pain management. The framework used by Greenhalgh et al. (2008) illustrates the spread and sustainability of innovations in service delivery and organisations, especially in health care organisations (See Figure 3.1).

In the context of this study, as noted in the introduction to this thesis, the management of pain in people experiencing pain as a result of cancer in healthcare settings in South Korea is a 'service delivery innovation' that warrants careful consideration of changes in practice. Given that this study centres on the experiences of nurses with providing care to manage pain among cancer patients, and the culture and context in which change such as the introduction of new models of care occur, Greenhalgh et al.'s (2008) conceptual model of the diffusion of innovation in organisations (the elements of which are outlined below) guided the study.

The elements include

- The innovation
- Adoption
- Assimilation: Diffusion and dissemination
- Inner context
- Outer context

As suggested by Figure 3.1, the spread of an innovation requires complex interactions among the different elements of the conceptual framework.

3.6.1. The innovation

Merriam-Webster (2016a) defines innovation as “the act or process of introducing new ideas, devices, or methods; a new idea, device or method”. However, OECD (1997) extends the meaning of ‘newness’ by including ‘an improved product that is an existing product whose performance has been significantly enhanced or upgraded (p. 32)’. Also, it defines the term, ‘product’ as something that covers both goods and services. The following definition of innovation in healthcare system that Greenhalgh et al. (2008) constructed is relevant to this study context:

... a set of behaviours, routines and ways of working, along with any associated administrative technologies and systems, which are 1) perceived as new by a proportion of key stakeholders; (2) linked to the provision or support of health care; (3) discontinuous with previous practice; (4) directed at improving health outcomes, administrative efficiency, cost-effectiveness, or user experience; and (5) implemented by means of planned and coordinated action by individuals, teams or organisations (p. 28)

Based on these definitions, development and publication of the CPMG in South Korea was an innovation at the time of its introduction. Indeed, there were no national guidelines that could help either healthcare professionals including nurses or non-healthcare professionals including government officials and the public prior to the publication of the guidelines to understand cancer pain management better. Therefore, any or all of these parties would have experienced barriers, such as lack of knowledge and education about pain management, communication issues, and inadequate drug supplements and dispensing, which possibly led to poor cancer pain management (Lee & Ahn, 2008). However, since the publication of the CPMG there have been major changes in supplying a variety of drugs, assessing patients and using different types of non-pharmacological procedures. This could change the health care professionals, particularly nurses’, cancer pain management practice significantly in the South Korean healthcare settings and improve the quality of cancer care (Lee, 2007). For these reasons, the introduction of the CPMG is considered an ‘innovation’ in cancer care in South Korea. Appendix 3.1. presents some of the standard innovation attributes, which

3.6.2. Adoption

Adoption is defined as ‘the act or process of beginning to use something new or different’ (Merriam-Webster, 2016b). Rogers (1995) particularly defines adoption as ‘the decision to make full use of the innovation as the best course of action available (p. 21)’. Greenhalgh et al. (2008) emphasise that people actively seek for innovations to experiment with, evaluate, find meanings in, challenge, complain and modify them and the nature of this adoption process makes the whole process complex. Appendix 3.2. lists some aspects of adopters and the adoption process that are relevant to this study.

As an individual adopter of the innovation, s/he goes through five stages, which includes the knowledge stage, the persuasion stage, the decision stage, the implementation stage and the confirmation stage (Berggren, 1996). Each stage can be determined as follows and is useful to identify nurses’ current location in terms of adopting the innovation, the CPMG, with their roles, care, and practice in this study;

- Knowledge stage - If intended adopters are aware of the innovation
- Persuasion stage - If intended adopters have attempted to form favourable or unfavourable attitudes to the innovation
- Decision stage - If intended adopters are involved in activities that can influence choosing adoption or rejection of the innovations
- Implementation stage - Innovations have been implemented or rejected
- Confirmation stage - Innovations are observed for their impact and reinforced

3.6.3. Assimilation: Dissemination and diffusion

Once an adopter adopts an innovation, it has to be spread by the process of communicating the innovation outside the original system (HIS, 2013). In particular, spreading the innovation within a team, unit, department and/or organisation is called

assimilation of the innovation (Greenhalgh, Robert, Macfarlane, Bate, & Kyriakidou, 2004). Indeed, successful individual adoption of the innovation is only one component of the assimilation of complex innovations in healthcare settings and assimilation of such innovation in the whole healthcare setting is much more complex process than the individual adoption of the innovation (Rogers, 1995). It requires the consideration of different stages of the process including moving back and forth among initiation, development and implementation, and facing different barriers, affecting factors both inside and outside the system (Greenhalgh, Robert, Macfarlane, et al., 2004). Effective innovation for an individual adopter may not be as effective in a team, unit, department and/or organisation which depends on the readiness of the group and each individual member of the group (HIS, 2013); and this requires more evaluation, experiment, challenge and modification as a group to make the innovation suitable and fit for the whole organisation.

Given that the study sought to determine the nature and extent of implementation of the CPMG in the study setting, analysing factors both facilitating and inhibiting would be helpful in looking for potential ways for how change based on EBGs might occur. There are two major approaches to spread dissemination and diffusion which are the two ends of the spectrum; this should be recognised as an indistinct and indiscrete approach (Greenhalgh et al., 2008). Whilst dissemination is defined as a planned, formal and centralised way of spreading innovation through vertical hierarchies, diffusion is defined as an unplanned, informal and decentralised way of spreading innovation through more horizontal and peer-mediated routes (HIS, 2013; Greenhalgh et al., 2004; Rogers, 1995). These two approaches should be strategically used in different levels in order to achieve spread of innovation in healthcare systems.

3.6.4. Inner context

Although, spreading the innovation might initially begin in individuals, it should eventually occur in a system, throughout the ward and the organisation. Hence, it is important to consider organisational context in order to enhance the spread of the innovation following its routinisation in the system. There are some contextual variables that indicate greater likelihood for adoption of the innovation described as below (Greenhalgh et al., 2008):

- Structure of the organisation - large in size, mature, specialised, differentiated into specific departments and units, decentralised decision-making structures, and extra resources available
- Absorptive capacity for new knowledge - organisation's ability to identify, capture, interpret, share and modify new knowledge, and ability to link with the pre-existent knowledge to use; supportive culture for learning; proactive leadership in terms of improving knowledge sharing both inside and outside of the organisation
- Receptive context for change - strong leadership; clear strategic vision with visionary staff in key positions; good managerial relations; allowance for experimentation and risk-taking climate; provision of staff training and adequate evaluation system

Along with those determinants of likelihood for spreading innovation such as the CPMG, it is important to know if the system itself and people within the system are ready or willing to spread the innovation in terms of enhancing the spread of innovation using characteristics as listed below (Greenhalgh et al., 2004).

- Tension for change - intolerable present situation that increase the needs for an innovation (e.g. In the nurses' quest for greater attention to the total needs of the patient)

- Innovation - system fits - suitability with the organisation's norms, values, strategies, goals and way of working (e.g. As reflected in the strategic plans and mission statements)
- Support and advocacy - more supporters for the innovation in the organisation (e.g. Greater scrutiny of the CPMG by nurse leaders for a 'nursing presence')
- Dedicated time and resources - budget line and adequate/recurrent allocation of resources (e.g. Interrogation of the implication of the CPMG for nursing activity)
- Capacity to evaluate the innovation - appropriate system and skill for monitoring and feedback (e.g. Involvement of all stakeholders in evaluation)

3.6.5. Outer context

The decision on adopting the evidence-based nursing practice based on EBGs such as the CPMG by a group of nurses can be influenced by aspects of the outer context such as inter-organisational norms and values, and collaboration (Greenhalgh et al., 2008). Therefore, analysing the data that represents and reveals the inter-organisational norms and values on pain management for those patients with cancer, use of EBGs to implement EBP in managing such issues, and MO-Registered Nurse (RN) and RN-family power relationships are fundamental in the Korean context.

3.7. Research Design and Methods

3.7.1. Research setting

3.7.1.1. Healthcare delivery system in South Korea

In order to have in-depth understanding of working culture in Korean healthcare system, it is essential to provide a brief description of the history and current future planning of the Korean healthcare delivery system. South Korea has three arms to deliver healthcare security as follows; National Health Insurance (NHI), Long-term Care Insurance and

Medical Aid (National Health Insurance Service [NHIS], 2016). The National Health Insurance Corporation (NHIC) is in charge of operating NHI, which cover national insurance for healthcare for over 96% of whole population (Song, 2009). There are some exceptions in terms of covering of benefits, which cause out-of-pocket payments for those non-covered services, although the coverage has been expanded over time (Jones, 2010; NHIS, 2014). Also, insured people have to be subjects for the co-payment system and have to pay for a certain portions of their service, 20 percent on covered service for in-patients care and 30 to 60 percent for out-patients care (NHIS, 2016). In order to rapidly achieve universal coverage, the NHI limited the coverage of benefits and set a low level of contribution rate, which now place more burden on patients who have critical and/or chronic health conditions such as cancer, despite the exceptionally low co-payment rate (5% for in-patient service) (Shin, 2007). Health suppliers including hospitals tend to use more non-covered services including medications and lab tests to cover the financial difficulties and often even make a profit (Jones, 2010). Furthermore, fee-for-service is the primary method by which healthcare suppliers are paid for their services with some use of case-payment for 7 diagnosis groups (NHIS, 2016); hence it appears that there are increment of service volume through provision of unnecessary healthcare services. This unique situation of Korean healthcare delivery system seems to influence healthcare professionals' decision-making on patient care (Park, 2002).

3.7.1.2. Acute healthcare system, the research site

Daehan University Medical Centre (DHUMC) (Pseudonym) in South Korea is the setting for this study. The DHUMC in South Korea is a tertiary teaching hospital in the capital city, Seoul, with 850 beds at the time of data collection. DHUMC has been a facility for patient care and dedicated to education, research and treatment for a long time. The Centre has several departments that include cardiology, endocrinology,

gastroenterology and hepatology, neurology, haematology and oncology, nephrology, and anaesthesia and pain medicine.

The Centre has been accredited by the Joint Commission International (JCI) ³ (JCI, 2016) and awarded several times for its achievements as a healthcare system including a 'Good Cancer Centre' (Lee, 2015b). It asserts that 'We promote the quality of human health and expand the prospect of world healthcare with the challenge spirit as the mission for the centre'. Details of its vision, strategies and core value are presented in Appendix 3.3.

There are three units that mainly provided care for cancer patients in the Centre and the characteristics of the major population in each unit are as illustrated in Table 3.1.

Table 3.1. Cancer Care Units

| Unit | Major population of the unit |
|----------------------------------|--|
| Haematology/ Oncology | <ul style="list-style-type: none"> - Patients with leukaemia, myeloma, lymphoma, pernicious anaemia - Patients with solid tumour such as lung cancer, stomach cancer, pancreatic cancer - Patients with stem cell transplantation |
| Surgical | <ul style="list-style-type: none"> - Patients with surgeries for cancer in stomach, liver, and small and large intestines |
| Gynaecology oncology | <ul style="list-style-type: none"> - Breast cancer - Gynaecological tumour including cancer - Thyroid tumour including cancer - Other gynaecological disease |

³ This is an international organisation that had been founded by the Joint Commission, which is the standards-setting and accrediting body in healthcare industry in the United States. It involves in accreditation of healthcare systems including educational hospitals in over 100 countries worldwide with the aims of improving patient-safety and quality of health care, and promoting rigorous standards of care and achieving best performance.

Patients are admitted for cancer treatment such as surgeries, chemotherapies, radiotherapies and other related symptom management. Operating a hospice care team was at the beginning stage at the time of conducting data collection and only selected patients as terminal stage were able to have hospice service.

The Department of Nursing is placed as a supporting department for medical treatment. It claims 'Improving quality of life by human (patient) centred holistic care' and 'Health restoration, health maintenance, health promotion and disease prevention of patients and their family' as the philosophy of the department. The mission of the department is 'Nurses who are trusted and loved by the customer (patients) through specialised knowledge and skill', which leads to the vision of 'Fulfilment of nursing ethics that are founded on Christianity', 'Improvement of nursing quality through evidence based nursing', 'Cultivation of the best system through transition' and 'Training excellent nurses through continuous education'.

3.7.1.3. Selection criteria of participants

The inclusion criteria for participants included the RNs:

- who had cancer care experiences of more than three years
- who were directly or indirectly involved in care of patients with cancer who were experiencing pain
- who were permanently employed on the study unit

Exclusion criteria:

- The RNs who worked in paediatric settings

The individual information session was provided to a total of 16 RNs from 3 different units. The study included 11 RNs who worked in the DHUMC and consented to the study. However, one RN withdrew from participating in the study, because of early delivery of her baby, so the total number of participants for the study became 10 RNs. The

demographic details of the participant nurses were collected at the beginning of the interviews and are presented later (See Appendix 3.4 and 3.5).

3.7.1.4. Entering the field and recruitment of the participants

Initially, the researcher contacted the Direct of Nursing (DON) by email to introduce both herself and the proposed study. Once she made an appointment with the DON, she visited the centre to discuss the plan of the study and to seek permission to access the possible study sites. During the visit, the DON was asked to allow the researcher to participate in one of the Nurse Unit Managers' (NUMs) meetings in order to provide a short information session/ presentation regarding the study. The DON supported the researcher and organised a brief meeting with the three NUMs from the units selected for the study. Also, the DON introduced the NE who helped the researcher to obtain the requirements, as the Institutional Review Board (IRB) of the DHUMC required the appointment of one of their staff as principal investigator, whenever the researcher was not one of their own staff.

An information session for the NUMs was held at the DON's office and the session included details about the aims of the study, what was being requested of potential participants for the study, the identified risks and benefits, and the ethical requirements of the consenting processes.

The three NUMs agreed on the information sessions for the participant recruitment, but they asked the researcher to provide individual sessions for individual nurses who would be willing to participate in the study for their convenience, instead of arranging any meetings outside the nurses' working hours. This was requested to reduce the burden on the NUMs and to ensure that the potential participant nurses were free from coercion or from influence by the NUMs when making the decision about whether to participate or not. All the nurses on the units were informed about the participant recruitment by the

NUMs in each unit with the written information letter (See Appendix 3.6). Also, the recruitment posters (See Appendix 3.7) were posted in the nurses' station and the changing room. Each NUM provided the list of the names and contact number of the nurses who showed their interest on participating in the study. The researcher contacted these nurses individually to organise individual information sessions and ensure their intention for participating the study was voluntary. Information letters (See Appendix 3.6) and consent forms (See Appendix 3.8) were provided during the information session (LoBiondo-Wood & Haber, 2010). The nurses were invited to consider their participation and return signed consent forms via the reply-paid envelopes provided. Nurses were encouraged to ask any questions about the study during the information sessions. Interested persons were also invited to call any of the research team members should they wish to have their questions answered. There were no questions raised.

Participants were asked to agree on:

- Being observed by the researcher during clinical practice for periods of eight hours over three shifts. The researcher observed participant nurses' conversation and actions and behaviours, such as how participant nurses provided care for cancer patients with pain, nurses' roles and functions in cancer pain management and whether their practice was consistent with evidence based international guidelines for cancer pain management.
- Being interviewed for up to one hour regarding their roles and perception of cancer pain management. Participant nurses were asked to clarify situations observed. The researcher asked questions about what policies, procedures and guidelines they used in cancer pain practice, their cancer pain management experiences and facilitators and barriers to the use of the guidelines in managing cancer pain such as CPMG.

Also, the researcher negotiated for a poster displaying the study to be placed in a prominent position in the study units.

3.7.2. Data collection methods

The data collection methods for this study included; 1) participant observation, 2) in-depth semi-structured interviews, 3) document analysis and 4) reflective journals.

3.7.2.1. Participant observation

The researcher undertook participant observation of care delivery prior to the interview in most cases, and review of the relevant documents such as the nursing task guidebook, patient information sheets and Electronic Medical Record (EMR)/Electronic Nursing Record (ENR) were maintained, during the participant observation. The contents of the participant observations, which included structural and organisational features of each unit, participants, their activities and dialogue, if the researcher considered it was relevant, and any other events were recorded in a field note diary with brief recording of emergent thoughts (Holloway & Biley, 2011). Then this was re-written as description in the reflective journal with further reflection.

Participant observation has been a primary method for ethnography from the beginning of its use (Gobo, 2008). Because the researcher has to spend certain amount time in an environment observing body language, gestures and sets of activities that occur (Grbich, 1999), the researcher can provide depth rather than breadth of data (Tappen, 2011). Thus, participant observation can enhance holistic understanding of the experience of participants, the practice culture and context.

Participant observation also helps researchers to identify any discrepancies between ideal cultural statements for example in the guidelines and what the participants describe and explain as the reality of the culture of implementation (Brewer, 2000). When the researcher conducts formal interviews it is easy for the informants to construct a picture of 'ideal' culture rather than 'real' culture (Murchison, 2009). Hence participant

observation is a fundamental method to reduce this risk of misrepresentation of the reality of practice, because it uses the direct evidence through the eyes of the researcher (Denscombe, 2010).

There are four different ways to do participant observation; being a complete observer, observer as participant, participant as observer and complete participant. Although, Denscombe (2010) stated that complete participant is the most suitable approach to keep the researcher's role as covert and discrete as possible to preserve the naturalness of the setting, it also has the potential for difficulties to arise for the researcher to gain consent from those being observed and thus to deal with any ethical issues. Nonetheless, observer as participant allows the role of the researcher to be publicly known and s/he may be able to access a wide range of information including some potentially hidden data, even though the researcher may not be able to fully understand the behaviour of participants (Tham, 2003). In this case, the researcher can use her experience to disclose things when aspects of culture and/or events are hidden (Denscombe, 2010).

In order to balance her position as a participant observer, the researcher was aware of the fact that her presence could alter the participants' behaviour and response in the study setting. It is not uncommon for participants to make positive changes, when they are aware of being observed (Wickström & Bendix, 2000). Therefore, it is critical to keep the study field as natural as possible to ensure the participants practise as usual. The researcher wore the lab gown as requested with her name tag on like other visitors and/or researchers who were there for clinical observation and/or study. She also used appropriate body language such as gentle eye contact and smiling, paying attention during the conversation and friendly demeanour, to build trusted and rapport-based relationships with the informants that reduced resistance/hesitation, but keep the participants and the field as natural (Allen et al., 2008). While the researcher considered such elements were needed to develop and maintain trusting relationships, she also

restrained herself so as not to 'go native' in order to maintain a critical view as a researcher (Borbasi, Jackson, & Wilkes, 2005). She maintained a reflective journal to reflect on her feelings, ideas and perspectives in order to prevent losing objectivity (O'Reilly, 2009).

In the case of this study, the researcher has experience of working in an acute care setting, where many cancer patients with pain and their related symptoms were managed in the South Korean healthcare system. Therefore, the researcher used this experience to help interpreting the culture and events associated with nursing practice for caring for cancer patients with pain; but also the researcher endeavoured not to limit the observation and interpretation to being in the frame of her experience only.

The researcher undertook observations as a participant observer and collected as much information as possible as approved by the Ethics Committee. Participant observation was continued over six months through three units of the DHUMC, where the RNs participated in the study. Each NUM from three different units provided a brief orientation that included some reminders that the researcher needed to remember during the stay for observation, on the first visit to each unit for participant observation. The NUMs also gave their user name and password to the researcher to be able to access the EMR/ENR. However, the researcher was told not to access a particular page, 'the interdisciplinary plan' in the EMR as the system would require the researcher to click 'approved' key to exit the page, which could change the status of the document and cause miscommunication among healthcare professionals. Hence, in order to prevent any incidence due to the automatic response of the EMR system, the researcher was limited in reviewing some contents of the EMR system; but she was able to access most EMR/ENR.

A grand tour observation of each unit was conducted at the beginning of the participant observation session and continued consecutively through the whole period of observation for the shift. During this time the researcher used the nine major dimensions of Spradley (1980, p. 78) for the descriptive observation as follows.

- Space: physical setting of the situation
- Actors: people involved in the situation
- Activities: various activities of actors
- Objectivities: physical contents
- Acts: the actions what actors do
- Events: sets of relevant activities that actors perform
- Time: the sequencing of events
- Goals: the things that the actors are attempting to achieve
- Feelings: the emotions in particular contexts

The researcher observed participant RNs' interactions with patients/family members or carers, other RNs and Assistant Nurses (ANs), and other healthcare professionals including doctors, to identify any events relevant to the study aims.

Through the participant observation, the researcher considered the following research questions.

- How do nurses provide care for the cancer patients who are experiencing pain?
- What policies, procedures and guidelines are used in cancer pain practice?
- What are the roles and functions of nurses in this context?
- Is practice consistent (or inconsistent) with evidence based international guidelines for cancer pain management? In what way or to what extent is this so?

- What are the barriers to cancer pain management and the use of the evidence based guidelines?
- What are the facilitators to cancer pain management and use of the evidence based guidelines?
- How is the environment set?

Thus, the researcher reminded herself to observe ‘what nurses did’; ‘what nurses asked’; ‘if nurses appeared to notice that patients were uncomfortable’; ‘if nurses tried to make patients comfortable’; ‘if nurses offer any pharmacological and/or non-pharmacological interventions’; ‘how nurses responded to patients’ request for pain relief at particular times’; and ‘if patients looked comfortable.’

The researcher was conscious of her role as a non-participant observer of the people in the field at the time of the observations. The researcher introduced herself to the nursing staff at each shift when she arrived, and the patients and their family members were informed at the early stage of each visit to the patients and provided with the written information statement (See Appendix 3.9). The researcher obtained written consent from the patients and/or family members, if they approved the researcher’s observation (See Appendix 3.10). This was provided not because the patients and/or their family members were the target of recruitment, but so they could be observed, while the researcher conducted participant observation for consenting participant nurses regarding their nursing practice with patients. The research notice (See Appendix 3.11) was posted in the public area in each unit for the patients/family members and for any staff members’ information; this notice indicated that the participant observation was in progress, and all were informed about the complaint process. However, there was no complaint made either from the staff members or from the patients/family members.

3.7.2.2. Field notes

Although there are some researchers who value field notes less in doing qualitative research, they can be the very essence of a study (Mulhall, 2003). They can be the fundamental source of analyses as they ensure the researcher can recall the time, place and event of the collected data, and can reflect on the data as written in detail, and comprehensively re-written.

After the negotiation of access to the field was confirmed, the researcher started an initial observation to see the underlying social situation which included place (three units), actors (participant nurses) and activities (nursing practice for managing pain among cancer patients) (Hodgson, 2001). Field notes were used as an account of what the researcher saw, heard, thought and experienced, and thus it minimised the loss of data (Streubert & Carpenter, 2011). During the participant observation, the researcher kept a small notebook and recorded any relevant data, whenever possible. Times and dates, physical environment, characteristics of people, emotional climate, sequencing and implicit understanding were recorded in the field notes (Tappen, 2011). The use of field notes was continued throughout observation and interview (Morse & Field, 1995).

However, the researcher took the approach of 'participating-to-write' (Mulhall, 2003); where the situation was not appropriate for making notes or the situation required intense observation without writing, ongoing observation was performed without field note writing of what was observed at the scene (Hodgson, 2001). For example, when participant nurses attended cancer patients for pain assessment or management and interacted with other healthcare professionals and patients, and their families, the researcher participated in observations first and took notes immediately after the events in a discrete location (Pope, 2005). Also, the researcher jotted notes at the scene when possible and developed comprehensive field notes at a later time (Mulhall, 2003).

3.7.2.3. In-depth semi-structured interviews

Interviews are an important element of ethnography along with participant observation (Germain, 2001). Interviews enable the researcher to recognise the participants' perspectives and clarify discrepancies among the participants and/or perceptions between the researcher and the participants. Interviews help researchers to draw a more complete picture of what happens during nursing practice and cancer pain management, because it can provide much more detailed information than other data collection methods (Roller & Lavrakas, 2015). Generally, interviews can be formal or informal, structured, semi-structured or unstructured, and individual or group. Interviews can be conducted during and after the participant observation sessions and are designed to explore questions relating to clarifying the meanings of language, behaviour and events (Holloway & Todres, 2010).

Structured interviews, where the researcher has a set of predetermined questionnaires that limit the informants' options of response reduce the ability for gathering rich data (Denscombe, 2010). On the other hand, unstructured interviews place the informants in a leading position to freely speak their minds. Even though, unstructured interviews are particularly useful when the researcher has very little knowledge on the topic on which s/he conducts the study, the researcher may face difficulties on managing the interviews and may require highly experienced interview skills (Morse & Field, 1995).

Semi-structured interviews, are the combination of some closed questions in the form of highly structured interview and open questions in a looser form and are useful in doing qualitative research given its accessibility to people's meaning-endowing capacities, and the form of extracts of language that has rich and deep data (Brewer, 2000). Morse and Field (1995) emphasised that semi-structured interviews ensure the informants talk about their stories in a way that explain the events, and asks for more detailed examples and stories. Semi-structured interviews require a clear list of issues that needs to be

addressed in logical and possibly chronological order. In addition, they are more flexible in terms of order as regards significances of issues and allow the informants to lead the interviewer to collect rich and deep data (Denscombe, 2010).

It is important to build a trusting relationship between the researcher and the participants during in-depth interviews, so the researcher can count on the integrity, ability and character of the participants, which are basic elements of a successful data collection process (Jokinen, Lappalainen, Meriläinen, & Pelkonen, 2002). Essentially, rapport involves trust and a respect for the interviewee and the information he/she shares. It is also the means of establishing a safe and comfortable environment for sharing the interviewee's personal experiences and attitudes as they actually occurred (DiCicco-Bloom & Crabtree, 2006). Throughout the data collection, the researcher consciously maintained the ways of achieving trusting relationship with the participant nurses. For example, when conducting interviews, the researcher spent a few minutes to establish an interactive relationship with the participants prior to the actual interview. It included asking general question about how she was doing or how the day went along with asking for completion of a socio-demographic questionnaire (See Appendix 3.12). The interview was commenced with a general question that asked about the cancer pain management experience that came to mind at the time.

The researcher used active listening and non-judgemental attitudes during the interview in order to enhance empowerment of the participants (Tham, 2003); hence the participants could express their opinions in their own terms (Tiainen & Koivunen, 2006). Whilst the researcher tried to be a good listener and not to miss any important cues offered by the informants (Murchison, 2009), she also endeavoured to remember that reflective listening responses would not be appropriate in the situation, because they could lead the informants (Morse & Field, 1995). Furthermore, the researcher asked the participants to consider the researcher as a nursing student who was on clinical

placement, ask for her opinion frequently, but express non-judgemental attitudes about her practice. The researcher provided ongoing information about the purpose of the study, maintaining confidentiality, use of the information and the result of the study in order to help the participants to trust the researcher and the research processes.

The researcher used the following methods to conduct effective interviews so that she could collect unexpected pieces of meaningful data, whilst she explored the issues within the culture on which she focused (Denscombe, 2010; Holloway & Todres, 2010);

- Taking notes in detail while listening: to record the important information in order to minimise any confusion that could be happening during the interpretation
- Often, taking note while listening can interfere with attentive listening, thus the researcher needs to balance between attentive listening and note taking
- Being sensitive to the informants' feelings; in this way the informants can express themselves better and give more relevant information
- Being silent and having non-judgemental attitudes to enhance the informants' willingness to speak up
- Being adept at using prompts, probes and checks when appropriate to draw out in-depth data

In this study, the researcher conducted approximately an hour-long interview in a quiet meeting room in the underground floor for every participant nurse using an open-ended interview schedule (See Appendix 3.13), which was developed based on the literature review, and research aims and questions. The interview schedule provided the researcher with a basic framework of what to ask and as the interview progressed, the answers of the participants led to further questions for in-depth understanding and clarification of the information. The researcher also asked extra questions, if any relevant issues arose during the observation. The researcher often jotted down the details of the information that the participants provided with describing gestures and voice tone.

Additionally, the researcher responded with frequent nodding, eye contact, facial expression, and gentle voice, and ensured she gave sufficient time for the participant RNs to think and talk.

However, the researcher was aware that it was not uncommon for people sometimes to embellish to seek 'social approval' and say things that were socially acceptable rather than what they believed or how they talked and behaved, and be able to critically process the information (Brewer, 2000). The use of participant observations helped to identify inconsistencies relating to the espoused beliefs, actions and behaviours. Also asking for exemplars and/or explanations of what they meant helped determine the consistency of the information.

The final sample size for this study, necessary to generate adequate descriptions of the phenomenon (achieving saturation) was 10 RNs. The demographic characteristics of the nurse participants are depicted in Appendix 3.4.

3.7.2.4. Document analysis

Document analysis supplemented the participant observation and interviews in order to attain both the widest choice of perspectives on issues and a complete data set for strong validity of the study (Germain, 2001). The documents can be formal, informal and official (Hammersley & Atkinson, 1995; Prior, 2008) and the type of documents that can be used for the purpose of the research can vary. For example, they include government publications and official statistics; newspapers and magazines; records of meeting; letters and memos; diaries; and website pages and the internet (Denscombe, 2010). The value of documents would be that the documents mostly have existed before the commencement of the study, and thus they follow the natural rules and regulations of the operation of the society and may provide longitudinal data (Brewer, 2000). Also, documents can hold vast amounts of information for the researcher to access with lower

associated costs and they are a lasting permanent record of developments in the field of study (Brewer, 2000; Denscombe, 2010).

However, documents, particularly the informal documents such as diaries, letters and memos can increase the risk of 'bias', which is why documents are more usually considered as secondary data (Hammersley & Atkinson, 1995). For this reason, every available document relating to the study aims was closely examined and the ones that were considered as relevant to the study were copied and filed for analysis later. The documents that were considered to be relevant were the formal guidelines on pain management including the CPMG; hospital philosophy of care and value with mission statements (See Appendix 3.3); philosophy of care and value with mission statement of the nursing department; relevant sections in the Nursing Task Guidebook (NTGB), which was a manual book for every RN; handouts on cancer pain management for patients; and records of the EMR/ENR system within the limitation of access.

During the document analysis, the researcher focused on answering the following questions.

- What is the philosophy of care in the unit?
- Are there any formal EBGs that drive nursing practice for caring cancer patients with pain?
- Are these guidelines on an international level? In what way or to what extent are they so?
- Is nursing practice for cancer pain management consistent (or inconsistent) with the guidelines? In what ways or to what extent is this so? (e.g. Pain assessment for the individual patients, details of interventions and evaluations for cancer pain management and documentation of nursing progress)
- Does the information statement contain enough/sufficient information for the patients to understand/use?

3.7.2.5. Reflective journals

As Finlay and Gough (2003) and Jacelon and O'Dell (2005) highlighted, a researcher is the major research instrument who actively performs the collection, selection and interpretation of data in qualitative research including critical ethnography. Thus, it is important to accept the fact that the subjectivity of the researcher has to be presented in the research, but it has to be within the right form and based on reflexivity. Researchers can achieve this through the critical reflection of their own thoughts and actions in relation to the research (Malagon-Maldonado, 2014).

For this reason, the researcher maintained a journal reflection record exploring her own experiences and interpretation so as to be aware of the interaction on the research between herself as a researcher and the participants, and its potential influences, in order to increase self-awareness of the researcher through the study. Maintaining and enhancing the reflexivity in the process of the research also can improve study validity and reliability (Finlay & Gough, 2003). Because of the researcher's position in a study and personal beliefs, power, privilege, biases and individual preferences, ethnography is often considered as prejudged and unsystematic. For example, the researcher was aware that her previous working experience in the Korean healthcare system as an RN and her cultural background of being a Korean had potential to influence the study during the data collection and analysis. However, reflexivity that involves thinking through gender, race, class, power, ethics and related issues, enables the researcher to constantly reflect on her own action/work and personal motivations (Scott Jones & Watt, 2010).

In this study, a journal was used to record the researcher's reflections on what has been observed with personal notes (See Appendix 3.14). Throughout the study, the researcher reflected on the way her personal experiences, pre-existing beliefs, perspectives and values might influence the study plan and implementation processes through the use of

a journal and memos. She reflected on how her views were changed by her research that was about understanding current cancer pain management in South Korea including nurses' actual practices and the use of the CPMG. Reflexivity ensured that the researcher included her 'self' in the research at the outset by making obvious her values and beliefs, as assumptions that might influence the study (Baumbusch, 2010). The researcher articulated her assumptions at the outset. This helped with better understanding of the dynamics of cancer pain management and the nurses' roles, and relationships found within cultures in South Korea (Speziale & Carpenter, 2007). Throughout the research journey the 'reflexive journal' and the contents of it formed part of the data collection and findings. This process of reflection showed the way her understandings of any emerging trends from the data change her worldviews.

3.7.3.Data analysis

This ethnographic study was undertaken to identify and have better understanding of the nurses' practices in relation to cancer pain management. By revealing their common practices around cancer pain management, the researcher assumed some aspects of their practice would be consistent with those within the CPMG, given their recent introduction in South Korea. However, as McCormack (2000) stated, people use multiple lenses to shed light on phenomena such as dimensions of pain experiences and their management; these would be evident in interviews. Differences in perspectives and reports might include use of language, reactions to the context of cancer care, and the influence of significant moments around pain management and patient care. Consideration of applying multiple lenses (Table 3.2) is necessary in order to construct and reconstruct the nurses' practice around pain management. Triangulation of multiple sources of data occurred at the analysis and interpretative process stages.

Table 3.2. *Applying Multiple Lenses to Shed Light on Dimensions of Pain Experiences and Management*

| | |
|----------------------------|---|
| Language | Nurses' focus on the use of words to describe how people experience pain; interpretation of the words used in the guidelines to describe the management of pain as a symptom |
| Context (Situation) | This is an acute care facility and all patients would have had some major treatment for cancer such as surgery, chemotherapy and radiotherapy which impacts on experience of pain and how nurses respond |
| Context (Culture) | This is an acute care facility, where there are social, political, cultural, historical and structural conditions that can have an impact on nurses' practice particularly relating to the use of evidence in their practice (the CPMG) in terms of managing pain for those cancer patients |
| Moments | There would be particular critical incidents or situations reported on or observed; these might have provoked pain and might also demonstrate how the nurse has responded |

The patients would be dealing with the diagnosis of cancer and the experiences of the symptoms, especially pain. They too would be reconstructing their identity and attempting to give meaning to their lives including the experiences of pain as one symptom of the health breakdown. Observation of nurses' interactions with patients would add to the researcher's understanding of the phenomenon as a result of interviewees' feedback.

Therefore, the researcher recognized the need for use of multiple lenses to comprehend or fully appreciate the reports on the field experience (observations, document analysis) and interview transcripts through the analysis process. By using different lenses mentioned above, the researcher could explore the nurses' role, routines and care practice, which they perceived as 'natural' and 'uncontested'.

Thematic analysis is defined as,

A method for identifying, analysing and reporting patterns within data. It minimally organises and describes your data set in (rich) detail. However, it also often goes further than this, and interprets various aspects of the research topic. (Braun & Clarke, 2006, p. 79).

Because thematic analysis is a flexible method, it can be used with a variety of theoretical frameworks, with reflections on reality and unravelling the surface of reality, as in nursing practice for cancer pain management (Braun & Clarke, 2006). The researcher followed six steps of thematic analysis as Braun and Clarke (2006) suggested (See Table 3.3). An audit trail of the analysis process is depicted in the Appendix 3.15 (See Appendix 3.15.1- 3.15.3).

Table 3.3. *Steps of Analysis*

| Steps of analysis | Description of application |
|--|--|
| Becoming familiar with the data | <ul style="list-style-type: none"> - Transcribing data - Reading and re-reading the data with noting down initial ideas - Development of 10 storylines from 10 participant nurses |
| Generating initial codes | <ul style="list-style-type: none"> - Conducting open coding to generate initial codes across the entire data set - Application of critical lenses (language; context-situation & culture; and moments) - Collating data relevant to each code |
| Searching for themes | <ul style="list-style-type: none"> - Comparing and sorting codes into potential themes - Gathering all data relevant to each potential theme |
| Reviewing themes | <ul style="list-style-type: none"> - Reviewing the themes to generate a thematic 'map' of the analysis - Applying Critical Incident Technique for selected data to scrutinise the analysis of data sets |
| Defining and naming themes | <ul style="list-style-type: none"> - Ongoing analysis to refine the specifics of each theme, and overall story the analysis tells - Developing clear definitions and names for each theme |
| Producing the report | <ul style="list-style-type: none"> - Selecting significant extract examples and final analysis of selected extracts - Relating back of the analysis to the research questions and literature |

3.7.3.1. Becoming familiar with data

In order to achieve comprehensive understanding of the data and to avoid any contamination from the researcher's own worldview, analysis of the data began as soon as the first data collection processes were commenced (Tappen, 2011). As Morse and Field (1995), McCormack (2000) and Braun and Clarke (2006) highlighted, immersion in and achievement of complete familiarity with the data through a process of active listening by searching for meaning and patterns, was the fundamental step for viewing the transcript through multiple lenses. Semi-structured interviews were transcribed verbatim in Korean by the researcher and the transcriptionist, and then translated into English by the researcher (See Appendix 3.15.1). Transcriptions were checked against the audio recording for accuracy and the English translation was reviewed by one of the supervisors who was also bilingual in Korean and English, and had nursing experience in both Korean and Australian healthcare contexts. Transcription in Korean was translated into English in parallel to the original Korean transcription by the researcher, so she could be immersed in what the participants said; this minimised any potential misunderstanding/limited understanding that could have arisen because of the limitation of language differences in expression of some terms and phrases. The researcher continued with ongoing reading and re-reading of the transcription word by word and line by line that required a series of movements back and forth (from recording to interpretation) in order to achieve saturation (Brewer, 2000; Hardcastle, Usher, & Holmes, 2006).

The researcher used an overview of the interview transcripts with noting down the initial ideas, participant observation data including data of document analysis and a reflective journal to write a storyline (See Appendix 3.15.2) for each participant in order to reach a stage of comprehension of each participant's background and experience. By identifying the key issues and initial findings, the researcher's reflections on the interview from each participant were recorded at a time when the data sets were fresh in her mind.

3.7.3.2. Generating initial codes

The researcher used 'open coding' (See Appendix 3.15.2) and separated each participant's story in an excel spreadsheet to draw common themes out of the thick description and allow for the addition of data from observations, document analysis and field notes. During coding, the researcher endeavoured to consider further interpretation what the participants stated and what the researcher observed by paying attention to the language within the text, acknowledging the complexity and richness of the potential impact of context on care processes and identifying and highlighting significant moments in the nurse/patient experiences portrayed in the text (McCormack, 2000). The researcher compared transcripts from each participant and analysis of categories (Morse & Field, 1995) and revisited for review of the initial 10 storylines again. This process provided an overview for comprehensive understanding of the data and its relevance to any use of the guidelines.

3.7.3.3. Searching for themes

After generating initial codes and revision of the initial 10 storylines, the researcher continued with comparing and sorting the codes to search for potential themes (See Appendix 3.15.2). The language, context (situation and culture), and moments were analysed simultaneously for better understanding of the meaning of the data in relation to the research questions. Then, each transcript was horizontally re-read in order to find the differences and similarities that could be presented by different participants. The researcher also paid attention to the unexpected information, which could be useful for a deeper level of interpretation. The researcher identified themes emerging from interviews, observations, document analysis and personal memos; these data sets were triangulated.

The researcher was aware that excessive coding could prevent her from seeing or fully appreciating the patterns and meaning of the content emerging from the stories. Thus,

she continuously moved in and out of the details of the data, continuously questioning herself and asking “What is really happening here?” (Thorne, Kirkham, & O’Flynn-Magee, 2004). Through further interrogation this enabled her to find other possible interpretations based on initial understanding- analyses of the data in different layers in a manner consistent with ethnography.

3.7.3.4. Reviewing themes

Those potential themes were reviewed in order to generate a thematic ‘map’. The researcher’s search for themes in the data through continuous reading, reflecting, coding, sorting, and reviewing themes enabled consideration of the validity of any individual theme. The relationship between codes, between themes and different levels of themes were tested out through drawing thematic maps for systematically elaborating on categories and linking to subcategories (Thorne, 2008). During the process, the researcher kept making comparisons and questioning the data while keeping the research questions in mind.

In addition to reviewing themes, the researcher used a Critical Incident Technique (CIT) for some data sets in order to identify the critical issues evident in nurses’ experience from the actual episodes of the management of pain among patients with cancer (See Appendix 3.15.3). As Bott and Tourish (2016) argue, CIT can scrutinise the analysis by shedding new light on the existing theories and/or concepts, which then minimises the possibility of taking their postulates for granted. CIT has been used in several different areas of practice, including nursing since the first development by the aviation psychologist Flanagan in 1954 (Kemppainen, 2000; Sharoff, 2008). Especially, it is believed that CIT is useful to have a better understanding about the roles of nurses and the interactions among nurses, patients and other healthcare professionals (Schluter, Seaton, & Chaboyer, 2008) through capturing the reality of the current nursing practice

and nurses' practice on cancer pain management (Sharoff, 2008). Schluter et al. (2008) further indicated that CIT method can be used for the following purposes;

- To reveal significant problems that are present in the system
- To identify both actual problems and potential causes of further problems
- To examine actual or potential strengths in the system that may ensure comprehensive practice for the nursing workforce

In order to be able to explain and interpret meaning from the data, the researcher endeavoured to view the data sets as a puzzle (Morse & Field, 1995). The researcher therefore constantly developed and scrutinised the data to develop the best appreciation of findings and relevant theoretical interpretation. This process enabled the researcher to use cognitive processes in interpreting, linking, finding relationships, inferring and verifying findings. Whilst interpreting the data and critiquing the findings, the researcher was committed to extracting meaningful interpretation with minimum changes to the intent expressed by the participants (Russell, 2004).

3.7.3.5. Defining and naming themes

This step of analysis, defining and refining the themes allowed the researcher to capture the essence of what each theme is about (Braun & Clarke, 2006). By composing the findings, the researcher identifies what each theme tells and how they connect to each other to be fitted in as part of a broader overall story in relation to the research questions, including 'What is the impact of the introduction of the Cancer Pain Management Guidelines on nursing practice in South Korean healthcare context?'. The researcher reviewed and revised the findings several times to minimise the overlap between themes. A total of 13 themes were classified into three superordinate themes and some themes contained further subordinate themes as presented in Appendix 4.1.

3.7.3.6. Producing the report

The researcher's reflection and interpretation on those findings was continued with refining the overall story. The conceptual model developed by Greenhalgh et al. (2008), referring to diffusion of innovation in organisations, guided the study in order to constructively analyse and present the data in relation to the research questions. In addition, as Thorne (2008) cautioned, the researcher recognised the need to add the use of published literature to create an imaginal access to the outlying storylines, in order to shed light on what some of the data might have contributed to better understanding of nurses' management of cancer pain in the acute setting. Therefore, Dowding's (2016) 'Hypothetico-deductive reasoning' guided the analysis of the nurses' experience of managing cancer pain, as every moment of nursing practice in managing pain requires the nurses' decision-making based on their clinical judgement. However, the researcher did not limit herself to answer the research questions only, but also extended her reflection and interpretation to understand the ideologies and issues that underpinned the findings.

3.7.4. Trustworthiness

Critical ethnographers should be able to access the voices and experiences of subjects whose stories might not be reached otherwise with all the resources, skills and privileges available (Madison, 2012). Tracy (2010) explored eight key elements that can ensure the quality in qualitative study and can strengthen the study. Table 3.4 describes the eight elements with brief explanation and how the researcher has applied each element in the study.

Table 3.4. *Eight Elements for Achieving Quality in Qualitative Study (Tracy, 2010, pp. 839-840)*

| Element | Description & Application |
|---------|---------------------------|
|---------|---------------------------|

| | |
|---------------------|---|
| Worthy topic | <ul style="list-style-type: none"> - When the topic of the research is relevant, timely, significant and interesting, the quality can be ensured. - Having in-depth understanding in terms of the impact of the introduction of the CPMG in nursing practice through the use of critical ethnography was considered relevant, timely, appropriate, significant and interesting. Particularly, as the CPMG was introduced for the last decade in the field of cancer care, it was meaningful to explore its impact in the nursing field, and identify any facilitating/obstructing factors for adopting/spreading the use of the CPMG in nursing practice. |
| Rich rigour | <ul style="list-style-type: none"> - Rigour of the study can be achieved through the use of sufficient, appropriate and complex theoretical frameworks, and data collection and analysis process. - The study used different data collection methods such as participant observation, document analysis, interview and reflective journaling. This variety of data source gave not only chances of triangulation that ensured the quality of the data, but also bounty of the data to provide research questions. - It used critical ethnography as the methodology with Foucault's theory about power/ knowledge and disciplinary power, and the conceptual model for the spread and sustainability of innovation in service delivery and organisation as its framework to achieve the aims of the study. - The data was handled with great care from the collection through analysis and to the storage as described in this chapter. |
| Sincerity | <ul style="list-style-type: none"> - Self-reflexivity, honesty and transparency are the important components of achieving sincerity, which relates to notions of authenticity and genuineness of the study. - The researcher revealed her background and assumptions of the study at the beginning of the study and maintained reflective journaling through the study. |
| Credibility | <ul style="list-style-type: none"> - Credibility is about trustworthiness and persuadability, thus the outcome of the study is trusted, and acted as evidence for decision making and behavioural changes. - Thick description through in-depth illustration of detailed data from 10 participant nurses over the 6 months of data collection period, and triangulation of the data by the use of different data collection methods and the analysis with different lenses were used to obtain credibility of the study. |

| | |
|---------------------------------|--|
| | <ul style="list-style-type: none"> - An audit trail of the data analysis (See Appendix 3.15) was substantiated to show the process of establishment of conceptual categories, relationship of the identified concepts to the data, and the core categories of answering the research question. |
| Resonance | <ul style="list-style-type: none"> - The study should be echoing and have impact on other people through aesthetic merit and transferability. - The researcher endeavoured to write with clarity and creativity, and in a comprehensible way that ensures readers' understanding and enjoyment. The findings of the study are believed to be relevant and transferable to the nurses who are working in healthcare settings in Korea for providing cancer care. |
| Significant contribution | <ul style="list-style-type: none"> - The study should influence theoretical, heuristic, practical and/or methodological matters of significance. |
| Ethics | <ul style="list-style-type: none"> - Obtaining ethics is a fundamental component in conducting qualitative studies and includes procedural, situational, relational and exiting ethics. - The study obtained ethics approval from the Human Research Ethics Committee at the University where the researcher was enrolled in the PhD program, and the Institute Review Board of the study setting. - The study was conducted in accordance with following all ethical principles as described under 3.6.5. ethical consideration. |
| Meaningful Coherence | <ul style="list-style-type: none"> - It is about achieving the stated aims of the study on previous knowledge with the adequate method and methodology. - The study was able to answer the research questions that led to achieving the aims of the study with the appropriate methodology, and methods of collecting and analysing data. Hence, meaningful interconnection among literature, research questions, findings and interpretation was obtained. |

3.7.5. Ethical considerations

Ethics approval was obtained from the University of Newcastle Human Research Ethics Committee (H-2012-0071, See Appendix 3.16) and the DHUMC IRB (ECT 13-12-08, See Appendix 3.17) before entering the field to conduct the study. The researcher completed a self-directed online-based education session for Good Clinical Practice that was run by the Korean Centres for Disease Control and Prevention as a requirement of

applying for IRB in Korea. The Principal Investigator (PI) was indicated as the NE in the study setting in the IRB approval, as the IRB at the DHUMC required one of its own staff to be placed as a PI in all research undertaking field work at the institution including research conducted by outsiders. However, the NE's role in this study was no more than a representative in terms of ethics approval at the DHUMC. Thus, the researcher gave a full explanation to the NE and obtained the Letter of Confirmation (See Appendix 3.18).

3.7.5.1. Informed consent and public notice

The nurses who participated in the study were given detailed written information (See Appendix 3.6 & 3.7) including the purpose of the study, the exact nature of their participation in the study, and details on ways of withdrawing from participation at any time with the ongoing opportunities of having face-to-face discussion with the researcher (Jokinen et al., 2002). Participation was voluntary with consent given freely (Tappen, 2011) and the participants were asked to use the pre-paid envelop provided to send the signed consent to the researcher. Process consent (Dewing, 2008) was used in this study due to the possibility for the situations of individuals to change by asking verbal consent before both participant observation and semi-structured interview in addition to the written consent. For example, one consenting participant did not proceed because the delivery of her baby was imminent.

The 'Nursing Research Notice' (See Appendix 3.11) was placed on the wall of the nurses' station to notify those non-participating staff, patients and families, and visitors, about the area being observed and that they had the right to avoid being observed. This was reinforced each time the researcher entered the observation area by ensuring the 'Nursing Research Notice' was in place.

3.7.5.2. Harm and risk

Participants were told that they could withdraw at any stage of the study without risk of any impact on their employment. Because this study did not involve interventions or any changes to the routine care for cancer patients, it was neither expected to harm patients or the nurses in the setting. The researcher was however aware that she should report any life-threatening situations to the nominated NE. Although some participants reported cases of malpractice, which could harm patients such as using placebos in managing cancer pain, the researcher did not observe an instance of this during the participant observation. Furthermore, two participants became emotional when they recalled the patient cases, where they could not manage the pain well, but the participants declined any need for professional help.

3.7.5.3. Privacy, confidentiality and anonymity

It was essential to maintain confidentiality of the participants to secure the participants' privacy. Because hierarchical attitudes prevail in the Korean culture, senior persons in positions of authority might have asked the researcher if they could review the observation field notes, for example, to review them for ways of improving practice. Manias and Street (2001) reported such experiences in their critical ethnographic study of exploring nurse-nurse and nurse-doctor interactions in a critical care setting. With this in mind, the researcher prepared for a similar scenario. In the event that a senior nurse requested access to the field notes the researcher planned to explain the matter of research ethics and the need to honour the research participants' privacy and issues pertaining to confidentiality. No such issue arose during the study. Particular personal discussions between the researcher and personnel in formal positions were managed with great care and cultural sensitivities in mind. The hard copies of information, field notes, interview transcripts and personal journal as work in progress on the day of the research were kept with the researcher as appropriate in a secure pass-worded laptop and later locked in a filing cabinet; and the data was only used for this study. All

participants were given a pseudonym to ensure anonymity in any reports or document. Maintaining confidentiality is the key step to gain a trustworthy relationship between the researcher and the participants (Jokinen et al., 2002).

3.7.5.4. Storage of data

The audio-tapes, hard copies of information, field notes, interview transcripts and personal journal were locked in a filing cabinet in the researcher's office until the completion of the study. Only the researcher and her three supervisors could access the data for this study. However, the person who engaged in transcription of interview transcribed six interviews, while the others were done by the researcher who obtained a Promise of Confidentiality Agreement Form for the Transcriptionist (See Appendix 3.19). All electronic files were password protected and a regular backup was made and stored in a secured location.

Conclusion

This chapter described the study methodology, design, conceptual framework and research plan and methods undertaken in pursuit of answering the research questions. Given that the researcher aimed to explore the experiences of nurses in the context and culture of the provision of optimal cancer pain management, it was important to critically analyse the data from observations and self-reports of the nurses' usual practices. The literature review demonstrated research previously undertaken in the context of pain management by nurses and provided professional insight into the facilitators and barriers to changes in practice in pain management. Chapter Four describes the study findings.

CHAPTER FOUR

RESEARCH FINDINGS

Introduction

In the previous chapter, the CE methodology used in the study was presented. In this chapter, the need for reporting on the experiences of nurses providing care within a Korean Health Service Speciality context in which people with cancer pain were seeking treatment was justified. As described in the introduction to this thesis, this study was designed to explore the impact of the introduction of national guidelines for the management of cancer pain, the CPMG as an 'innovation' that was part of usual practice for people hospitalised for cancer care, treatment and management. The hospital complex in which the participant nurses were employed, was given an award for excellence as a care provider for patients with cancer. The award was largely based on outstanding care for cancer care including pain management at a time when the CPMG was promoted as a central feature of cancer pain management. The introduction of the CPMG in the healthcare settings in this study sought to explore the concomitant changes to nursing practices.

In this chapter, the researcher presents the findings of the study. Here the experiences of participant nurses revealed the nature of their patients' pain, their suffering and the challenges the nurses faced when caring for their patients.

The following excerpt highlighted the nature and extent of pain suffered by patients in this setting and one nurse's realisation of its extent.

The patient came in through the ED. She came in for abdominal pain [due to ovarian cancer]. She [The patient] would be free from pain [due to the tumour she had], once she had surgery to remove the mass. With cancer ... Maybe, [the removal of the mass] could relieve the abdominal pain, but she might still have pain from surgery. Having Chemotherapy or RT [Radiation therapy] could also cause pain, couldn't it? See, if you see only pain [no matter the cause of the pain], I don't think there is any difference between the initial pain due to cancer and the pain during the treatment [the patient could have

pain arising from the treatment process], because it is a process [of the treatment]. If the patient is cured, then pain may be decreased [pain issue may be resolved], but during the treatment, there would be not be much difference... (Kyoungmi).

Unlike many of the nurses in this study, who thought the patients' pain was only due to cancer, Kyoungmi suggested that the pain could arise for a range of reasons including treatment such as chemotherapy and radiotherapy. In a specialised Korean healthcare setting, cancer pain management is the central focus of 'usual' care for nurses.

Three superordinate themes (ST) described below, suggest that, i) the CPMG was not used to guide nursing practice in this particular study setting; this limited the researcher in answering the original superordinate research question, '*What is the impact of the introduction of the Cancer Pain Management Guidelines in nursing practice in South Korea healthcare context?*' The findings in ST 2 showed the usual practice of nurses was not based on a level of evidence such as that underpinned in the development of the CPMG. The nurses' experiences reflected a level of dissonance and incongruence between what they thought about pain management and responses to patient care dictated within a medically orientated environment. This included the dynamics of how nurses made decisions for patient care in managing pain. The chapter also provides an analysis of the nurses' personal experiences of managing pain providing context to understanding the complexity of managing pain and the nurses' responses in ST 3. The following Table 4.1. illustrates the outline of the themes that emerged during analysis of the data, and Appendix 4.1 represents the relationship between the themes and the research questions. The content of the CPMG and the current practice of the nurses identified in themes are compared in Appendix 4.2.

Table 4.1. *Outlines of themes*

| Superordinate themes (ST) | Themes | Subordinate themes | |
|--|--|---|--|
| CPMG Innovation: Is it evident? | Seeds of innovation | Guidelines for nursing practice | |
| | | Lack of receptivity for change | |
| | | Resources for the management of pain | |
| | CPMG: Stimulus for changes | Hospital accreditation | |
| | CPMG: "We don't know much about it" | Changes in leadership, changes in practice | |
| Nurses' usual practice for managing cancer pain | Recognition of cancer pain | Initiating nursing care: Use of greetings in pain assessment | |
| | | Looking for cues and inferences relating to pain | |
| | | Patients' experience and knowledge: Misconceptions and negative perceptions | |
| | | Patients' preferences for doctors, not nurses | |
| | | Nurses' misconceptions, misperceptions, and lack of knowledge | |
| | Nurses' responses and actions on recognition of pain | Inadequate or limited assessment | |
| | | Influence of beliefs on inappropriate responses | |
| | | Pain assessment tools: Various and selective use and interpretation | |
| | Making decisions about pain management | Reliance on pharmacological interventions | |
| | | Non-pharmacological interventions: Limited use | |
| | | Influential factors on decision-making | Excessive workload limiting quality nursing care |
| | | | Nurses' attitudes and assumptions |
| | | | Non-redeemable nursing activities |

| | | | |
|--|---|--|--|
| Nurses' experiences of managing cancer pain | | | Lack of patient education on pain management |
| | | | Inadequate education for nurses on pain management |
| | Evaluation of nursing actions: Guess work and minimal practice | | |
| | The dynamics: Family, MO and the nurse | Family: Helpful/unhelpful | |
| | | Medical hierarchy and medical dominance | |
| | | Desire and reality: The dilemma for nurses | |
| | | Negative workplace behaviours among nurses | |
| | Roles and functions of nurses in usual practice for managing cancer pain | | |
| | Professional dissonance: undervaluing nursing actions | | |
| | Sense of powerlessness and frustration: Therapeutic intent vs. patient outcomes | | |
| | Anger and failure to embrace unique characteristics of patients | | |
| | Incongruence reflected in the professional mirror | | |

ST 1. CPMG Innovation: Is it evident?

The findings suggested that the CPMG were not used as a guide to nursing practice in this particular study setting. However, the analysis indicated some elements that suggested 'system antecedents' and 'readiness'. The first superordinate theme, 'CPMG Innovation: Is it evident?' emerged from the focus on determining the nature and extent of nurses' uptake of the CPMG as EBGs.

The superordinate theme, *CPMG Innovation: is it evident?* captures several elements of the uptake of the CPMG. The theme, *Seeds of innovation* describes the use of guidelines by nurses.

Theme 1.1. Seeds of innovation

The study observations of nurses interacting with patients suggested there was no evidence of use of the CPMG, but there appeared to be some elements within the system to aid the 'spread' and 'sustainability' of innovation, if the CPMG was introduced to nursing practice and applied to manage cancer pain. These elements included the use of guidelines by nurses, and that there was a receptivity for guidance in practice.

1.1.1. Guidelines for nursing practice

The Nursing Task Guidebook (NTGB) was the major source of directions for all nursing practice including pain management of patients with cancer as part of their comfort and care.

The 'NTGB' included four different pain measurement scales that nurses could use for the patients in different circumstances as follows; NRS (Numeric Pain Rating Scale), PAFS (Pain Affect Faces Scale), NIPS (Newborn Infant Pain Scale), and FLACC (Face-Legs-Activity-Cry-Consolability Scale). According to the NTGB, nurses were required to assess the patients' pain intensity, location, pattern, frequency and duration by using the pain scales; record the nursing intervention; report to the doctors, if there was any unrelieved pain after

interventions; and provide adequate education about pain to patients and families (Field note, summary of NTGB).

The 'NTGB' across multiple units provided some guidance for nursing interventions for pain:

- Nurses should provide **explanation about pain scale** and pain management by handing out pain management information sheet [on admission]
- Nurses should **screen for the presence of pain**
- Pain assessment/evaluation should be scored by use of the pain scale
- Pain assessment/evaluation should be **done with assistance of the pain scale**
- Pain assessment/evaluation should include pain intensity, location, pattern, frequency and duration
- **Nursing progress documentation** should be obtained when intervention is provided
- If **no improvement after the intervention**, nurses should **report to doctors** and obtain nursing record (Field note, summary of NTGB-Section 9).

Jinhee noted the use of a resource, saying

We do have a guideline [NTGB] to train the new graduates and also the checklists... //... we have one in the unit and every new graduate has a guidebook.

One nurse in the Ladies' Unit for gynaecological treatment, was aware that they were required to assess every patient with pain on admission and transfer, and three times a day during each shift thereafter, as instructed in the NTGB

... it is our routine job, in situations [for example], when they [the patients] came in for admission, we ought to do pain assessment for all those patients... [When there are] admissions and/ or transfers from other wards, we must do the initial assessment and then [at least] once every duty as a routine practice, at set times... (Youngsook).

In the Oncology Unit, the requirement for assessing pain every shift at scheduled times, 8am, 4pm and 11pm, and recording assessments in the 'Pain Record' as written in the NTGB, guided the nurses' routine in the study setting.

There is a hospital policy that has been set. I mean, we attend to pain assessment once every shift... and enter pain score [in the EMR system]// [it doesn't matter if patients have pain or not] we attend [to checking of pain scores] as a routine (Eunsoo TC3).

It was clear that the 'NTGB' provided a framework or model for the assessment of pain with the 'Pain Record' in the EMR system. The following are examples of records, which show the responses to the prescribed framework in the NTGB. The framework followed the 'Nursing Process' (Nursingprocess.org, 2018), including nursing diagnosis; plans and the goals of care for the nursing diagnosis; the interventions as per the plan; and the evaluation of interventions. The 'Pain Report' provided examples that the nurses could select from a drop down box on the computer.

During the participant observations, the use of EMR system, including the nurses' use of the 'Pain Record' was reviewed. The 'Pain Record' required nurses to select the relevant information from pre-determined items: 1) patient's identity label, 2) pain scales, 3) severity, 4) frequency, 5) duration, 6) location, 7) description, and 8) reasons either situational evaluation that takes place on certain occasions such as admission, transfer and post-analgesic and/or routine evaluation (Field note, Eunah).

@0700

D [Diagnosis] Acute pain: operation

O [Objective data] Pain NRS 4 (on 0-10); Frequency 3-4times/8h; Duration 10min; Location Operation site; Types Throbbing pain; Cause Acute-Chronic pain;

G [Goal] Pain decreased less than NRS 2.

P [Plan] Evaluating pain severity, frequency & duration, location, and pattern (pain assessment tool); Encouraging verbal expression of pain; Administering prescribed analgesic.

I [Intervention] Evaluated pain severity, frequency & duration, location, and pattern (pain assessment tool); Encouraged verbal expression of pain.; Administered prescribed analgesic (Tridol 1 ampoule IV)

@0800

E [Evaluation] Pain measured NRS 1, no further intervention wanted

(Jinhee's Pain Record in

EMR)

The drop-down box items prompted nurses to ask relevant questions of patients in order to assess their pain. However, the use of the 'Pain Report' was not adequate when nurses assessed patients with more complicated pain as the form did not include prompts for aggravating factors, such as any psychological distress and certain movement, alleviating factors such as rest and application of heat/cold and the patients' usual practices when managing their own pain. For example, in a more comprehensive

approach to pain assessment nurses should ask questions such as “Is there anything you are worried about?” and “How do you usually manage pain when you are at home?” in order to understand more about the pain issues that individual patients were experiencing (SIGN, 2008). Nurses tended to ‘click’ responses within the electronic ‘Pain Record’ in the EMR to show that they had provided patients with some advice and a level of nursing care indicated within the ‘NTGB’. Although there was a space at the end of the ‘Pain Record’, where they could enter more information in regards to the assessment and management of pain, this was often left blank. Nurses did not routinely make individualised notations for the patients in their care.

Eunah demonstrated her ability to identify an area to be improved and expressed her desire for improvement. She even commented that the ‘Pain Record’ needed to be revised.

*I think it [the Pain Record] should be described in more detail. There could be the patients who are suffering chronic pain that can't be simply described as something... like throbbing pain or sharp pain, couldn't there? Also, the location of pain is a bit [unspecific in the Pain Record, so it should include more body parts to indicate the location of pain]. Comment sections [for each assessment item] could be added [in case of adding notes], and is needed... **categories with more details** (Eunah).*

Although Eunah and other nurses were aware they could add relevant descriptive information, they tended to close the form once they finished choosing from the given examples without adding more information. The researcher noted during the study observation periods and review of documents that most nurses did not provide extra descriptions that could promote better understanding of the individual patient's cancer pain experience, or the severity or the locations of their pain.

However, it was noted during observation and review of the relevant documentations that there was limited evidence of adequate information or directions with rationales for nurses to make decisions in their practice for managing cancer pain. For example,

although the nurses followed the NTGB that instructed nursing practice, the content was very limited, especially around descriptions of interventions for pain. The NTGB classified the interventions into pharmacological and non-pharmacological, without justification. For example, mention was made of pharmacological interventions including opioid analgesics, other drugs that could improve pain and PCAs, but there was limited information or details about individual drugs including precautions for each drug to which nurses should pay attention. The content of the NTGB did not appear to be systematically developed, that is, with a level of evidence and nursing perspectives; they simply instructed nurses to perform the task of managing pain within medically driven structures and processes.

1.1.2. Lack of receptivity for change

A lack of receptivity to change was reflected through the following excerpt in which Jinhee explained her views of the organisational constraints to innovation in her practice.

The atmosphere of the hospital is not something like [someone would want to initiate any ideas/practice], but just take orders and to do it [follow the order]. // ... it [trying to initiating the ideas/ practice] could be another sample of behaviour [that is trying to] draw people's attention [because the one who initiates the ideas/ practice would 'stand out' and people would recognise her/ him]...// we don't really like it [behaviour that draws people's attention]. // ... I don't like to draw other people's attention for myself and also I don't think... it will look good, if other people behave like that [draw attention to themselves] (Jinhee C-VII-3).

Strong leadership from managers, who are supportive in adopting the innovation and have good relations with the nurses are considered important elements as receptive context for change. Nari reflected on her NUM's **suggestion** for her participation in the study causing her to think about her own practice.

Participating in an interview like this has made me to think about my original intention [to become a nurse]... and I think I might have been working without much attention to manage pain and things like that. Initially, when I was invited to participate for this study, I responded in a negative way. I [even] said to

the Head Nurse “Do I really have to do this much?” and she said jokingly “That’s why you don’t grow [within your profession].” [But, now I can see] even participating in an interview like this gives me an opportunity to think [about my own practice]... A study like this helps me... [Now I feel] thankful [for her to challenge me to participate in the study] (Nari).

On the other hand, an embedded hierarchical relationship among nurses was apparent which limited openness and demonstrated a non-receptive culture thus limiting chances for communication among the nurses as Jinhee said *I hardly talked with the Head Nurse. She's a little bit hard to face...* (C-VII-5).

Support should be in place for adoption of the CPMG in nursing practice to improve cancer pain management. However, such support was not reported or observed in this study.

1.1.3. Resources for the management of pain

In order to use different interventions to provide individualised care in managing pain for those patients with cancer, nurses needed to have sufficient level of support. Despite the positive effects of extra material resources that could increase the chance of spreading and sustaining the CPMG, the participants often reported limited availability of resources. A lack of equipment supply for non-pharmacological interventions such as hot packs was reported in two units. Jina noted safety reasons, that some equipment such as hot bags was removed from the healthcare setting without replacement with safe alternatives such as heat pads and heat lamps

... we used [hot bags] pouring hot water in it, but it had a risk of burn, so we can't use it anymore (TC17).

Given the removal of potentially dangerous hot packs for abdominal pain, some patients brought their own equipment for ancillary use in addition to the prescribed analgesics. This highlights concerns about limited knowledge and understanding among the nurses

who did not advise patients about safety when using ***infrared rays or something like that... some sort of medical equipment...*** (Jeongmi TC17), as the equipment was brought in by the patients without any recommendation from healthcare professionals particularly nurses.

Human resources who could provide a variety of non-pharmacological interventions including professional therapists were reported to be limited, despite its effectiveness of enhancing pain management outcomes. Some interventions that were known as effective could be more complex in terms of instruction, thus needing professional instructors, such as art therapies. However, as there was no internal and/or external access to professional instructors, the nurses appeared to believe

*It would be better to have professional [therapists] for those music or art [therapies] than us, but that **there is no one who could come...*** (Jina A-VII-20).

On the other hand, it was reported and observed that even providing a simple level of music therapy was often ignored due to a busy workload with insufficient staffing in one of the Units, where there was a music room.

We have music played in a music therapy room ... meant to provide emotional support and make people relax. Patients said it is really helpful to be in that room to listen to the music. So we made the room, but now... we often even don't play the music. If we got really busy in the morning we forgot to turn the music on... (Eunah D-VII-12)

Although, some participants appeared to have learned about certain non-pharmacological interventions in their practice, they often lacked confidence about their use in nursing practice noting they were not certificated for this.

*There are many activities like art therapy and music therapy... I couldn't use them although I knew them, because **I was neither a professional [instructor] for those therapies nor had a certificate for it, so I didn't know much about it, I only could participate in the activities and give some help*** (Younhee TL40).

Even if EBGs such as the CPMG were introduced, optimum outcomes from the adoption of the EBGs would not be achieved, if nurses' choices on interventions were limited due to inadequate resource support or confidence to use the resources they had.

Theme 1.2. CPMG: Stimulus for changes

In this study context, it appeared that any tension for changes in managing pain did not arise from the individual nurse's reflection on their own practice. Instead, it was externally mediated because of the hospital accreditation and changes in a medical consultant's attitudes towards cancer pain management.

1.2.1. Hospital accreditation

As noted in the previous chapter, the study hospital setting is one of the few tertiary education hospitals in Korea accredited by the JCI. The aim of the accreditation system is to improve patient-safety and quality of health care, and promote rigorous standards of care and achieve optimal levels of performance. Hence, all study sites were formally recognised as quality healthcare settings once the JCI accreditation was achieved; this consequently could enhance their reputation. In relation to the recent hospital accreditation, Miho noted

*... I think **it's quite effective. It has the marketing effect [given]** that we have achieved JCI accreditation, in this country... this is one of the few hospitals that achieved the foreign JCI accreditation... **I've heard that we've got increased numbers of patients, since the accreditation** (F-IX-4).*

It appeared to Miho that the accreditation process influenced the introduction of some changes in this healthcare setting such as introduction of the EMR; an innovation in itself ... ***the [hospital] system has been totally changed** and there has been more work done electronically* (F-IX-4): The hospital installed computers with programs to support

patient care systems. This in turn led to change in nursing practices such as maintaining a 'Pain Record' and this mandated regular pain screening/assessment as a routine.

*'All patients are screened for pain and assessed when pain is present'- I found in the JCI accreditation guideline under the section **patient access and assessment that pain screening and assessment are specifically stated** (Field note, Miho).*

In theory, the tension for change imposed by the accreditation and the consequent changes in the use of 'Pain Record' in the EMR, demonstrate readiness for the uptake of other innovations such as the CPMG. However, the participant nurses considered changes in their practice arising out of accreditation as suboptimal; they were frustrated and pessimistic. They considered the accreditation requirements and processes caused too much indirect activity for them (i.e recording of what they did during their shift) and that this reduced time for direct nursing care. This theme is presented later in this chapter.

The changes in nursing practice resulting from the hospital accreditation without nurses' understanding of changes increased doubt amongst nurses about its value in relation to patient care and pain management as Eunah suggested

*... the hospital started using the EMR for the purpose of the JCI accreditation. Nurses now had more frequent checks on for the patient, but **Eunah was not sure whether it was worthwhile to keep recordings such as completing frequent 'Pain Report'** and thus have less time to provide hands on care (Field notes: Eunah).*

Irrespective of the Unit, given the nurses' perceptions about the value of the accreditation and the changes to practice, any changes seemed to reflect a 'temporary performance' rather than achieving longer-term changes in practice aiming for better nursing care in managing pain.

*We [the hospital] **wanted to show off to patients that we've gone through the accreditation and achieved it in order to promote its reputation**, so I think [preparation for accreditation and changes in the hospital] was **organised without clear plans...** (Miho).*

Regardless of understanding the purpose of accreditation, the nurses said it was important to comply with the accreditation criteria, but it did not change their long-term practice including pain management.

During the accreditation... When the JCI came [to assess for the accreditation], we actually went and asked the patients with numbers [physically attend the patients to assess pain with numeric pain scale], how much pain they had, because we were told that they [the auditor] would also go and ask the patients [if we had come to assess pain with the scale] (Younhee E-VII-9).

For example, because it was very important to record their nursing practice consistent with expected levels to maintain accreditation, the nurses completed the EMR in order to leave a record trail.

Since the documentation has become important, it seems like we were clinging to it, because we have to leave adequate documentation [including the 'Pain Record'], it takes so much time... (Jina TC26).

During study observation, it was noted that nurses spent much time on documentation in the EMR; but the nursing record in the EMR was limited in details and hence lacked providing information to communicate with other healthcare professionals including other nurses. The changes to documentation that occurred in the setting aimed to improve the quality of care and promote the reputation of the setting as a high quality healthcare system. However, the quality of the nursing documents in the EMR was suboptimum and the nurses struggled with their basic care processes due to work overload caused in part by the EMR and a lack of resources. In response to references to the use of non-pharmacological interventions such as psychological support, massage and touch, Younhee said

Only when I've got a bit more time ... I've let those terminal stage patients rest on me [my shoulder] for a while [if appropriate] (Younhee TL62).

One can see from the above that the nurses in the study were frustrated about the demands for the level of care that they were expected to meet, and pessimistic about the influence of accreditation on their own practice and patient outcomes without sufficient resources. The absence of the use of EBGs in their practice to manage pain

among the patients with cancer was apparent, so was the frustration and pessimistic attitude toward accreditation.

1.2.2. Changes in leadership, changes in practice

Another indicator of tension for change was noted when there was a change in medical leadership, which influenced approaches to the management of cancer pain and increased use of analgesics. A newly appointed medical consultant with experience in hospice care meant that the use of placebo, previously a common practice in this setting, was almost abolished. Miho noted the change of attitude towards pain management from the new vice-president of the hospital and this meant changes in the overall medical team's approach to cancer pain management. The registrars and the residents used less, almost no placebos since the vice-president of the hospital was also the consultant of the hospice team and her views heavily influenced pain management in the unit.

*The **biggest reason [of the changes in not using much placebo] would be the professors**, because there has been changes in what they think. **Previously [the professor] didn't pay much attention on such problem [pain issue]. Well... but now they've been taking [the issue of] pain really seriously.** Therefore, if a patient complains of pain, they do their best to [reduce pain]. // And **Professor OOO has become the Director of the Medical Centre, hasn't she? She has been [involved in] hospice ... And I think it [Professor OOO and her involvement in hospice care] was the reason why we have a hospice team** (Miho).*

The role of the Director of the medical centre heavily influenced the practices of not only MOs, but also nurses. Such changes in leadership were a positive step towards possible changes in nursing practices.

Theme 1.3. CPMG: "We don't know much about it."

Only one nurse in the study acknowledged the existence of the CPMG, but even though the Centre in which she worked promoted itself as excellent in treating cancer including

symptom management of pain. She did not use the guidelines in reference to her own practice.

There is a guideline for use of opioid, isn't there? Something like you use it [this guideline] like this in this situation and if it's [use of certain opioid analgesic is] not working, use something else... like this... But actually, we don't know much about it [the CPMG] (Nari I-VI-1).

This ignorance of the CPMG was acknowledged by the participant and also observed by the researcher; the nurses' practices of attending to pain screening/assessment often depended on whether the nurses felt they had enough time to do so during the rounding rather than according to the CPMG, which recommended frequent screening and comprehensive assessment.

I visit the patients, once I have handover ... and if I have enough time, I start asking questions to the patients [who are] on the first or second day of post-operation. I also open [the site of the operation in] their tummy and ask "Do you have severe discomfort anywhere?" or "How much pain do you have?" (Jeongmi G-I-1).

When Miho described how MOs in her unit (Haematology/Oncology) prescribed and used opioid analgesics, it appeared that there was some level of understanding of the concepts that influenced implementation of EBP by using CPMGs. This detailed description by Miho could be an indication of evidence that the CPMG at least was introduced to the MOs in the study setting, although the participant nurses were not aware of it.

When patients are admitted ... most patients would have been in pain, right? Then assess them first and if they say they are in pain, whether they had a patch on or were taking oral medications, they're all stopped, but then [we] restart Morphine. // Give Morphine and control the pain with the Morphine first, but if the patient keeps complaining of pain, the doctors increase the dose and adjust... keep adjusting and if the pain is controlled [with certain dose], they use a patch, [with] the same strength [of the Morphine]. They change it like this and if the patient has pain after patch [application], then they add oral analgesic (Miho F-I-2).

However, practices were not always consistent with the CPMG. For example, there were reports of decisions about analgesic doses not being based on collaboration with the interdisciplinary team of healthcare professionals'. Decisions reflected requests from the

family which negated the directions of guidelines around dosage of the pharmacological interventions. Inclusion of responses to family concerns meant that patient advocacy sometimes overrides direction within the Guidelines.

At first, we were worried about patients being sedated, but then again because we started with too little [analgesic], the pain wasn't reduced much. So, the patients who were in terrible situation [experiencing pain], their family asked for them to have no pain, so we increased the dose little by little, disregarding sedation (Nari TM14).

Despite some indications that the CPMG or at least relevant evidence-based principles might be introduced to MOs, there was no evidence reported or observed that nursing practice was driven by the CPMG or its principles.

ST 2. Nurses' usual practice for managing cancer pain

The second superordinate theme focused on participants' reports on observed current usual nursing practice around managing pain for those patients with cancer. These were illustrated in observations of a sequential process.

In reporting the observations of the dynamics of nurses' making decisions about pain management, the researcher noted the involvement of all parties including the family, the MO and the nurse. The ways of responding to the presence of pain were 'transactional' and not always inclusive of realistic assessment of the patient's experience.

Theme 2.1. Recognition of cancer pain

Under this theme, findings illustrate how the nurses recognised the presence of patients' pain. This included the use of greetings to determine if further pain assessment was needed and acting on cues and inferences from the patients to recognise cancer pain.

2.1.1. Initiating nursing care: Use of greetings in pain assessment

Participant nurses initiated care with the use of common greeting words that any Koreans would use when they met each other. In this situation, however this greeting seemed to lead the conversation to more detailed pain assessment and/or any interventions to manage situations involving pain. As well as setting the tone for the therapeutic relationship between the nurses and the patients, it also provided an opportunity to initiate deeper conversations on any issues including recognition of the presence of pain.

*We come and say “**Anyounghaseyo** (안녕하세요, Hello)” to them or ask “How are you doing today?// [Then] If I ask “Oneul mwo **Pyeon-anhasyeoss-eoyo** (오늘 뭐 편안하셨습니다, Have you been comfortable today)” “Eodi mwo **Bulpyeonhandeneun Eob-seusyeoss-eoyo?** (어디 뭐 불편한데는 없으셨어요, Have you got anywhere [where] you feel discomfort?”, then the patient starts telling me with what s/he has felt the most uncomfortable ... (Jina L1).*

'Anyoung (안녕, 安寧, being well, hello)' is used as an interjection to greet; and this has a meaning of 'being well', 'being peaceful' and 'being safe', when it is used as a noun. 'Pyeon-an (편안, 便安)'; the status of being well and comfortable without suffering, pain, anxiety or worry and 'Bulpyeon (불편, 不便)'; the status of being in physically, psychosocially and/or emotionally suffering without being well; discomfort, have opposite meanings that indicate a person's status of physical, psychosocial and emotional wellbeing, but they are all used to determine, if patients are in pain or not. This illustrates that use of greetings not only can open the relationship between nurses and patients, but also provide opportunities to recognise the presence of pain, if the words are used consciously. Nurses could recognise the presence of pain from noting physical, psychosocial and emotional factors. Use of the term 'comfort/discomfort' in initial greetings could cover a broad range of pain related issues and lead to identification of specific pain-related information. This was evident in Jina's comment.

If I ask “Have you been easy [comfortable] today?” “Is there... anywhere you feel discomfort?”, then the patient tells me [about] the most uncomfortable first... then I will eventually get to the point “Have you got any pain anywhere?” (Jina TM4).

However, it was often observed that some of the participant nurses used the phrase as a greeting to the patients without progressing into meaningful conversation about pain issues when they were in a hurry during rounding. They appeared to say ‘Anyounghaseyo’, quickly checking on intravenous fluid lines and operation sites, then leaving without further conversation or pain assessment; this routine had the potential to miss important cues to the presence of pain.

2.1.2. Looking for cues and inferences relating to pain

Participant nurses’ interest in knowing if patients were in pain or not was shown through their behaviours, for example looking for further cues or gathering more information on the patients for example when

*Miho **asked if the patient complained of any pain** during the day among those patients she had to look after during the evening shift* (Field notes: Miho), or when Jina said she noted the nurse at handover noted that

*they had pain... [so she would be] **saying she did such and such things [provided certain interventions] because of pain*** (TM2).

Eunah recognised if patients with cancer had pain given that

*... about **70 to 80 percent of the patients**, I know [they were in pain] **because of their [verbal] expression*** (Eunah TL4).

Youngsook noted reports from a carer can be a source of recognising the presence of pain because

*When patients had severe pain, but they were closer to the terminal stage, **they might have difficulty to speak about it*** (J-III-2).

The patients often seemed reluctant to report pain; this led to inadequate assessment of pain and thus inadequate interventions. Many patients presented as stoic. Miho (TL29) and Jina (TL27) noted that patients denied pain or they did not report pain, delaying reporting it and/or under-rating the severity or intensity of their pain. Otherwise they would say

... it's OK", "it's OK [I don't have pain]"... just like that... but there are people looking like they are in pain... like crunching their back and sitting and frowning... or I often see the monitor [EKG monitor] and the heart rate is increased... something like this... or sweating with like cold sweat, then I keep asking if the patient really has discomfort. (Jeongmi, TL26).

Another way of recognising pain was through observation of the patients' non-verbal expression such as changes in behaviour and facial expression, especially within a group of people who were frequently readmitted to the service for a range of ongoing therapies.

We are getting the patients who are repeatedly visiting us. //Thus, we kind of know the characters of each patient a bit. Their names and things... But if they are not talking much or [prefer] being alone too long or otherwise really keep grimacing or not having their meal or really bothered when we talk to them, [I know they might be in pain]. There are patients who show through [changing] their behaviours or talking that they are in pain (Kyoungmi TL3).

At other times, their previous experience of patients was known; Kyoungmi acknowledged the patient was in pain

... if a patient has the same chemotherapy a couple of times, they would have some side-effects. I ask the patient in advance like "Don't you have numbness in your hands or feet?" "Haven't you got any burning sense in the tips of your fingers?" (Kyoungmi TC6).

Nurses appeared to use a variety of cues and inferences to recognise the presence of pain and related issues. However, there were cases when pain experience was overwhelming to both nurses and patients because of the complex nature of pain and an individual's response to certain cancer treatment that caused pain.

For example, Jina, who was working in a Haematology/Oncology Unit at the time of the interview recalled her memory of two patients who had serious pain issues on post-chemotherapy of Methotrexate (MTX). A patient with leukaemia, Daewon, had MTX chemotherapy for treating his disease and because of skin irritation developed severe pain for about 2 to 3 days, after the chemotherapy. However, she could not see any abnormality on the skin until it was actually peeling off.

This patient had chemotherapy and now complains of pain due to its side effects. But, the pain that this patient is complaining of is not bone pain or

anything like it. He is **suffering from pain [resulting from breakdown] in the whole skin**, so it almost **terrifies him** even with a little touch. He would be **screaming** [in response to] a brief grazing. The **unknown origin of the pain** continued for 2~3days [initially], and you **couldn't find anything wrong in his skin [from just looking at it]**. But, he suffered from this pain and 2~3 days later.... **his skin was peeled off**. So, the skin on his sole has peeled off like some kind of slice... (Jina).

The pain was severe, so he was terrified by even a slight touch. Jina noted that the pain that Daewon had, was one of the extreme cases that the healthcare professionals including nurses had difficulty dealing with, as initially they could not see any changes in the skin. The following excerpt under Theme 3.2. illustrated clearly how much Jina struggled when she could not find any cues or inferences about what caused the pain, and hence was unable to manage Daewon's pain.

2.1.3. Patients' experience and knowledge: Misconceptions and negative perceptions

Nurse participants believed that patients under-reported pain due to their misconceptions about the symptom. The patients appeared to have a belief that the pain would be improved and/or lessen with time as Eunsoo (TL31) noted, "*Some patients who don't say anything [that they are in pain] they are the ones who think **it would get better if they hold off.***"

Patients also revealed negative perceptions towards the effects of analgesics on recovery and their own health when the nurses asked further questions to confirm the presence of pain and/or offered pharmacological interventions.

*I ask "Do you have pain today? Do you have discomfort somewhere?" Then they say "Yes, now I've got some pain, but it was OK [before]". Then I ask again how much pain they have... If I ask "Can I get you some pain killers?" those kinds of patients [patients who hold off pain] **refuse analgesics, either**. They say **they'll hold off pain without having analgesics. They think analgesic can delay recovery...** so there are patients who say **NOT having analgesic will help recovery...** so they hold off (Eunsoo TL31).*

Such negative perceptions seemed to limit patients' willingness to take analgesics in many cases, hence their hesitation to report pain.

There were patients who did not know how to use the pain scale or the meaning of each number; this resulted in difficulty in pain assessment as described in previous themes. However, as Younhee stated the patients who had more experience of being hospitalised for their cancer treatment sounded more familiar with the use of pain assessment tools and with understanding the meaning of numbers. They appeared to communicate better with the healthcare professionals including nurses about their experience of pain. This indicated that patients could well understand how to describe their own pain on the pain scale, if they had experience and thus an adequate level of understanding.

The patients who got admitted a few times, have some knowledge on the concept of NRS, [and they would] compare [their current pain level with] the previous pain level and let us know (Younhee TL56).

However, it did not appear that the Units or the Hospital promoted ongoing pain management focused education for the patients. Some participant nurses denied that there was any education for patients and others stated that there were few temporary education sessions for patients that related to pain management.

[I think] we do [have patient education sessions], but I don't remember well, because I wasn't really interested in it. But I remember there was [a post] stuck on [the side of] elevators (Eunah).

Although Miho described how patients were given information, it was noted that providing information with the written resource was not always part of practice, but was often missed. Moreover, if the patients still had difficulty in reporting their pain and communicating with the healthcare professionals, including nurses as reported in the previous theme, this could indicate the education provided might not be readily understood even if used amongst patients.

When a patient is admitted, we provide a Pain Management Information Sheet [a single A4 size information sheet as it was instructed in 'Nursing Task Guidebook'] and explain that the patient needs to remember the 0 to 10

pain scale and answer us, when we ask if s/he is in pain. [We also say that] they can talk to us about whenever or wherever they have pain or discomfort, they can tell us (Miho TM10).

The 'Pain Management Information Sheet' commenced with a question '*How much pain do you feel?*', and followed by asking '*Please, evaluate how severe your pain is*'. Then, it continued with a brief explanation about NRS and PAFS (Pain Affect Faces Scales), and a brief statement of options for interventions that included pharmacological (opioid and non-opioid), non-pharmacological and other interventional procedures. This information sheet was meant to be used as a written information resource with instructions for patients on when to report pain.

It was 'Acting' nurses (new graduates or less experienced Korean nurses, who worked more on 'hands on' care tasks such as fluid rounding and injections, monitoring routine vital signs and admission care) who gave quick education sessions to patients as a part of admission processes. They gave the 'Pain Management Information Sheet' on patients' admission, as they were responsible for care on admission. However, whilst some were observed to use the 'PMIS' on admission, others stated that they did not have any written information material that they could use. This could indicate the absence of continuity in using materials or less attention placed by some on adequate pain management.

A head nurse in Unit XX said that the ward didn't have any written information material for neither patients nor nurses. ... I could see that most of the EMR of cancer patients had records of 'Pain Management Information, giving explanations regarding pain management with an information booklet' of an intervention they gave. Also, Miho gave me a sample of the 'Pain Management Information Sheet' that nurses were using (Field notes: Miho).

Initial information received and occasional brief education activities during routine care seemed to be the only education opportunities for the patients. Not surprisingly, patients' lack of knowledge was demonstrated in fears of tolerance of and addiction to analgesics. The patients believed that if they started taking analgesics once, they had to live with

analgesic for the rest of their lives. Nurses like Kyoungmi and Miho appeared to take such situations as an opportunity to provide correct information and education when they recognised patients' fear and misperceptions about the use of analgesics. However, Miho noted it did not always change patients' negative perceptions while Kyoungmi said

There are quite number of patients who don't say they are in pain despite being in pain because of the inadequate knowledge [about the use of analgesics]. Then I would educate them again. I explain "No, [it is not correct. Taking analgesic would not decrease the effect of analgesic later]. It is better for you to take [analgesics] in order to overcome pain at this stage, because pain can be controlled by analgesics." They keep refusing, because they've been told [before they were hospitalised] that it is not good for them to take analgesics and also once they start taking analgesics, they have to keep taking them. Also, there are some patients who refuse taking analgesics, because [they've been told that] now they take one tablet, [it means] they would have to take two or three tablets in the future [to control pain] (Kyoungmi TL31).

These perceptions could exist because of inadequate public information or a lack of patient education about the use of analgesics including potential adverse effects of analgesics. This appeared to increase fear amongst the patients, and hence under-reporting of pain.

2.1.4. Patients' preferences for doctors, not nurses

There were some reports of certain patterns in reporting pain among patients that could cause difficulties for nurses in recognising pain. For example, Jeongmi described her experiences of those older patients who wanted her to call MOs after refusing her approaches

... there are some patients who say they don't want to talk to nurses, but ask for doctors, or [say] they will tell when the doctors come... It is quite common for the older people do so. Then I would just get the doctors for them (Jeongmi G-VII-8).

Nurses guessed or assumed that patients were in pain, if doctors ordered new analgesics. Even if patients did not report their pain to nurses, Jina (TM1) said they often reported this during the doctor's rounding "... ***if the doctor has already ordered***

medication, [I consider and say to the patient] "Ah... that's why the doctor has ordered the medication [for you]."

Similar to Jeongmi's report, Jinhee believed that the patients were clear in their expectations and set the tone for responses from nurses. She also reported her experience of patients' preference for medical over nursing interventions:

*There are times when **the patients get upset, if it takes some time for us to do assessment**, they rather want to have analgesics right away from the doctors ... (Jinhee).*

Patients' reliance on or preference for MOs and their authority is reflected in what they tell MOs; this is different from what they tell nurses. It did not seem to be surprising for the nurses to experience patients' different reporting behaviour to MOs and nurses, as Jina also illustrated.

*Well, I mean there are times that what we assessed is different from what **the residents or the professors [consultants] assessed** in many cases. There were **patients who denied [pain] when we asked, but said "I had pain such such occasions"** or **"I've got pain when I move"** when the professors asked... (Jina TM19).*

Such behaviour could be due to their perception of the value in seeing a member of the medical profession rather than seeing a nurse: **[The patients think] doctors know better than nurses...** and doctors are more intelligent than nurses (Jinhee, C-IX-14).

This could lead them to consider that doctors' interpretations of pain were more accurate or reliable. The value of the nursing perspective is undervalued.

2.1.5. Nurses' misconceptions, misperceptions, and lack of knowledge

While there were many patients who under-reported pain; there was a small number of patients who seemed to constantly report pain and request analgesics frequently. The participant nurses seemed to experience some level of doubt about 'Recognising' patient self-reports of pain, due to their own misconceptions, misperceptions, and lack of

knowledge. This was evident when they considered the patients' frequent report of pain as over-reporting.

There are patients [who say they are] “Always in pain”... I become conflicted [there is a doubt] in me if I [can] trust those patients or not ... But because they say they are in pain, I give them analgesic as same [like I do for other patients], I give them same interventions, but I [consider it] a bit differently, when I measure it as a number... (Kyoungmi TL20).

Eunah also reported their own misconceptions about pain “... **because patients in our ward are more likely early stage with surgery or chemotherapy [pain should not be a major issue for them].**”

Such doubt could also be a reflection of nurses' negative perceptions towards the use of analgesic, in a similar manner to that of patients'. The following excerpt illustrates nurses' perceptions when faced with patients' frequent pain reports and requests for certain analgesics.

***He kept asking for Morphine.** Although we said pain was subjective,... he didn't seem to be in pain when I saw him, also he seemed OK when the doctors saw him... but **he kept saying ‘painful’ ‘painful’.** Then I gave him other analgesic, but he said ‘Ah, it wouldn't work for me... give me some Morphine.’... he kept asking for it. So, [I thought he was addicted and] **the doctors [also] would think he was ... addicted...** (Miho).*

It was not uncommon to see the nurses' concern in regards to dependency and tolerance of opioid analgesics, when patients frequently requested certain analgesics. This could indicate the nurses' lack of knowledge about the use of pharmacological interventions and the influence of commonly used terms such as addiction, dependency and tolerance such as Jeongmi noted

*it seemed like opioid analgesics can cause **dependency or tolerance...** I've seen a patient who **kept asking for certain analgesic.** Well, because we use Pethidine a lot, he asked for the opioid analgesic continuously, I became **unsure if he was really in pain or he just liked to enjoy the feeling of ecstasy,** so I became doubtful ... (Jeongmi).*

Given such misconceptions and negative perceptions towards the patients with frequent pain reporting, the nurses could distrust patients' self-reports of pain and use of certain analgesics, and treat the patients in an unprofessional way. Absence of adequate

assessment with socially and culturally embedded perceptions appeared to cause mistreatment of patients.

I think I treated the patient in an unfriendly [unkind] way. If the patient came out, I said “he’s out, he’s out again to ask for Demerol” something like this... Also, when I notified the doctor, [I said] “He’s asking for it again... asking for it again” like this... a little bit like with the businesslike attitude, even without pain assessment But as it repeated again and again, I became just like business like... Really I treated the patient like ‘Junkies’ at the end... (Jeongmi).

Kyoungmi shared her experiences of patients who appeared to report pain more frequently than she expected to be reasonable. The desired outcome is not the management of pain but attention and sympathy. Such firmly held perceptions or beliefs that the nurse had from her own experience caused doubt about the patients’ self-report of pain.

There was a patient, who didn’t have a good relationship with her husband, so she only complained of pain, when her husband was there [to get empathy from him]. // Also, some grandmas would say [they are in] pain, when their sons are there... // [They want to] be seen as [patients] ... to be recognised as a sick person... // Then they become alright. Then there are some grandmas, who seem to be embarrassed, because they know [that they pretended to be in pain]. I mean they might be acting like that because they want their sons to come and visit them often or it might be they don’t want their sons to go back [but stay with them longer] (Kyoungmi TL5).

Given the different circumstances of pain experiences among patients with cancer and their behaviour in terms of reporting pain, and how nurses perceived such experiences and behaviour, pain experiences appeared overwhelming, not only impacting patients but also nurses.

Theme 2.2. Nurses’ responses and actions on recognition of pain

Once nurses recognised pain, they responded and took several actions including assessment, intervention and evaluation sequentially and/or concurrently. Theme 2.2 illustrated the practice for managing cancer pain as sequential processes.

2.2.1. Inadequate or limited assessment

How nurses respond to the recognition of pain would be an important moment of decision-making. Some nurses like Jina (TL7) asked questions to prompt the patients' report of pain, once they noticed actual pain or risk of escalating pain. *I see their facial expression [and ask] **"Why are you frowning? Have you got somewhere [that is] uncomfortable today?"***

On the other hand, it was noted and observed that the nurses' pain assessment was often limited by levels of screening that only focused on presence of pain and the intensity. Even if they stated that they inquisitively asked the patients about pain, their approach to assessing pain was not based on the principle of pain being a multidimensional experience.

*I ask **"Do you have pain today? Do you have discomfort somewhere?"** Then they would say "Yes, now I've got some pain, but it was OK". Then, **I ask again how much pain they have...** (Eunsoo TL8).*

There were nurses who simply asked the patients to let them know when they were in pain without conducting a comprehensive assessment, despite their sense of a discrepancy between what they observed and what the patient reported.

*There are **patients who seem to be in pain [but say that they are not in pain]**, aren't there... because of cancer pain... Then... If the patient says "I'm OK at the moment", I usually say **"Then please let me know when you have pain later"** (Miho TL16).*

Some nurses instructed the patients, who wanted to bear the pain at the onset of the symptoms, that they should let the nurses know if the pain became much worse rather than giving adequate information to the patients to prevent/minimise the pain.

*Then if I asked **"Then what should I do for you?"** and they said **"I'll hold it off a little longer."** Then I said **"if it becomes really bad, tell me. Just tell me, without hesitation"** (Youngsook TL16).*

Although, some nurses used verbal and/or non-verbal expression as cues of being in pain, Jinhee (TL3) reported that she did not consider the patients were in pain, if she did not observe certain behavioural changes ***I don't think they are in pain [if they sleep well after surgery].***

And Jeongmi (TL19) suggested ... ***if they are sitting there with looking like no problem or reading a newspaper, I would just pass through them most of the time [with no pain assessment].***

Similar to Jinhee's statement above, Jina tended to consider that no report of pain or relevant issues from patients during the handover meant no actual pain or pain-related issues were present during the previous shift. Therefore, she did not initiate further assessment.

*I asked Jina if there were no patients with pain issues this morning. She answered me **if there was one, the morning RN would mention [that there was]**, but because the morning RN didn't say, **she guessed there was none** (Field notes: Jina TL14).*

This approach is certainly not adequate and does not meet the NTGB and EBGs including the CPMG, but was often observed and reported by the researcher.

2.2.2. Influence of beliefs on inappropriate responses

Nurses often showed their assumptions on cancer pain as the type of pain directly due to cancer, and hence assumed it should/would be severe. Some nurses including Eunsoo expressed her understanding of cancer pain as a physically unpleasant sensation due to cancer itself and considered that cancer pain should be severe in its intensity.

*Although **there are few patients who complain of pain because of cancer pain...** they are more [likely to be] in the oncology ward... **Those terminal stage cancer patients** receive hospice [care]... Patients are managed for their pain in that ward [oncology ward] ... There are a **few terminal stage patients***

here in General Surgery [Unit] who came in for pain management here... but not that many (Eunsoo L42).

Eunsoo's perception suggested she underestimated the pain that occurred through treatment; possibly, she was less sensitive in her responses to mild to moderate pain. Eunah also showed similar perceptions that appeared to influence her attitude towards nursing practice. She appeared to rationalise the limited current nursing practice on pain management as something unavoidable because the nurses would have less interest and pay less attention to less frequently reported issues. This could be due to her perception of cancer pain, that it would only include severe pain and in a busy work situation that led the nurses to prioritise.

If the ward is full of terminal cancer patients [who would have severe pain], the nurses would have more interest [in knowing about and performing better practice for managing pain], because they have to deal with such issues. But our ward is mostly acute stage patients and there might be one patient [with pain] among the patients that I have to deal with [in terms of managing pain]. I think this is why we don't feel much need [for knowing about pain assessment and management] (Eunah TL18).

Such perception could lead the nurses to limit their practice, being more task-oriented, and hence preventing nurses taking action on pain management.

Some nurses expressed discomfort in asking the patients directly and using the word 'pain'; hence, they tried to follow up on cues, arising from expressions of discomfort.

RN Jina also stated that "I can't directly ask the patient if they are in pain, when I do rounding. So, I ask them "Do you have any discomfort?" instead. Then if the patient responds with something, I ask for more detail" (Jina TC11).

When it was obvious that the patients were in pain, some nurses appeared to avoid asking questions to assess pain in such situations; rather they provided analgesics and evaluated pain later by asking if the given analgesic decreased their pain. This could be due to the professional expectation from the patients that nurses should know they were in pain after surgery; they might consider asking questions as reflecting their incompetence as healthcare professionals or bothering the patients.

*Well, for the patient who just had surgery, **you can't ask them "How much pain do you have?" right away**, can you? Because they must be in a great pain [after surgery]... // they even **look to be in pain**... [so] **I just say [to the patient] "I'll give you the pain killer now"** and I give it... **then later**... after I've given the analgesic, **I visit the patient** maybe in an hour's time, while I'm doing the rounding, **[I ask the patient] "Is your pain decreased?"** Then I do the pain score [recording pain score] (Eunsoo TC11).*

The nurses seemed to have a concern about patients' irritation if they asked detailed questions when the patients were in pain.

*See, now **the patients are irritated because of pain** and you ask them a question "Between 1 and 10, how much would you give?" **They all would say "10"** and there are many **patients who would be irritated by this [being asked to indicate their pain]** (Eunsoo TL22).*

It appeared that the nurses were reluctant to face emotionally challenged patients, and hence inadequately approached pain assessment. The participants were often observed to avoid asking about pain when they visited the patients during the shift. On some occasions, pain scores were recorded in the 'Pain Record' and the nursing progress notes in the EMR, when nurses' actual visits to patients or their assessment practice was not observed.

2.2.3. Pain assessment tools: Various and selective use and interpretation

Although pain assessment tools, such as PAFS, NIPS and FLACC were introduced in both the 'Pain Record' and the 'NTGB', NRS was consistent with the demands of the EMR and thus the most commonly used tool for those nurses in their routine care for the patients with cancer.

***I ask the patients with NRS.** I ask "How much would your pain be, if 10 is as painful as if you were gonna die and 0 is no pain" (Miho TC5).*

However, the participants also reported that there were some patients who were not able to describe pain, because they did not know how to estimate their pain on pain scales.

Younhee shared her experience about patients who could not appropriately measure their pain using NRS.

*The **patient said her pain was 8**, then I would say to the patients “We consider the pain that [someone can experience] when we [she] give[s] a birth could be about 8. What would be the [your] number?”... [Then the patient would say] “I don’t know.” **There were many patients who couldn’t decide** [the number that describe their pain at that moment] like that. Then **I would explain them again... and then [the patients would say] “Would this be 4? No, no... About 7? Well, I’m in pain...”** Something like this, they would become indecisive... // There were some patients] who said that [because] **they didn’t know [how to use NRS, so they wanted me to] explain** (Younhee TL28).*

It appeared to be difficult to provide numbers that represented the severity of pain, because the patients did not understand the meaning of each number on a scale. The nurses gave some examples of the situations where the patients might have previous experience of pain; so, the patients could have some idea of the severity attached to each number.

*Initially, some patients... [say] “No matter what, it is 10 [on NRS]”, if pain is too severe, they would say like this. Or otherwise, some patients say “How should I say it [express pain in number].” If the patient says like this, ... because **we have more married women patients who had experiences of child birth...** if I say, “Well, **you should recall the moment you gave a birth and the pain you had that moment would be about 9 to 10**, and that’s the worst pain you ever had. Can you say it again based on those criteria?”, then they would briefly say it [the score] (Nari TM5).*

Whilst some nurses provided examples to help patients identify numbers to describe the pain that they were experiencing, others seemed to manipulate the way of asking about pain severity without using recommended pain assessment tools such as NRS. For example, some nurses stated that they modified ways of asking questions in order to attain a score consistent with their own description for the NRS. When patients provided verbal descriptions of pain, they interpreted and translated this into a numerical score based on their view because their patients would not understand the meaning of each number.

*Usually, I **use the number in the chart**, but ... [First] I **ask the patients if they have pain**, [Secondly] **if the pain is bearable or unbearable and [lastly] if they think they need [analgesic] injection**, then [I ask them to] talk to us... It’s like **3 steps [of asking questions]**... (Younhee TL23).*

Furthermore, some nurses even recorded their interpretation of the score regardless of pain score that patients reported.

In a situation like this [the patient states high numbers, but says s/he can bear it], I also feel really uncertain... Of course, the scale, I think it has been made objectively, but I don't think it can be commonly used for everyone... [So] in a situation like this, I might enter [the score] as I like [change the score that I interpreted to keep a record of pain management], because they said they could bear it... (Jina TM26)

Regardless of how the nurses modify their approach when using assessment tools, this could be inappropriate at times as the pain assessment tool or communication source, because there was a lack of consistency in use and the interpretation of scores. The participants considered that the pain scale could be too subjective to use, because there was discrepancy between the given scores and patients' responses to the pain.

They [the patients] say they can tolerate it [the pain], but then if we ask them to describe in numbers they would say it is 8 [out of 10], although we explained [them] that it [the pain score 8] is intolerable [on the scale], [and] it should be around 4 [if they can tolerate the pain]... and if it is unbearable worst pain that they can think about, then it should be 10, they still would say it is 8, but they can hold off (Jina TL24).

When the meaning of numbers on pain scales were understood by individuals and the patient expressed an estimation of their own pain based on their understanding, but the latter did not match the nurses' expectation, some nurses seemed to doubt the patient. One started looking for facial expressions and tried to influence the patients' claim, however, she also had felt guilty about making a subjective judgement sometimes even changing to her own value judgement for scores, rather than taking the patients' self-report.

The nurses further stated that the 'Pain Record' had a set of instructions for interventions such as 'provide analgesic' when they entered a score, which exceeded certain levels, and leaving a record of the proof of what they provided to manage the pain in the EMR. Hence, the number was considered very important in terms of nurses' practice on pain

assessment and management for those patients with cancer. This could indicate that the nurses were more focused on following instructions to complete the tasks of getting a numeric score to enter in EMR rather than understanding the patient's pain, seeing the patients as individuals and a person with particular needs. The 'Pain Report' in the EMR would have been placed there to promote the nurses' professional practice by reminding them of what to assess using their own clinical knowledge and critical thinking skills. However, it seemed that the requirement of completing the form was a priority and that nursing practices appeared to be limited. The nurses insisted they needed to match the patient self-reported pain score with the score that they interpreted

... we felt [thought their pain] as about 5 to 6, but they often said it was 2... But the chart ['Pain Record'] said [indicated] to give analgesic when it [the score of the pain] was greater than 4 [exceed certain number on a scale]... And we thought the patient needed analgesics [even though s/he said her/his pain was 2] and the patient also agreed on a need for analgesic, when we asked. It was a bit difficult to use in the real field... Use of NRS was somehow difficult... (Younhee TL24).

Many patients did not seem to be able to use the pain score system. They did not understand the meaning of the score. The nurses seemed to have imposed their own assessments and judgements without attempting to get to the essence of pain management. It was clearly noted that there was various and selective use and interpretation of pain assessment tools.

Theme 2.3. Making decisions about pain management

2.3.1. Reliance on pharmacological interventions

Participant nurses stated that pharmacological options were the primary interventions that nurses used to manage pain. As it was seen as very important to maximise the effectiveness of the interventions, using all available options based on evidence can be considered critical to optimal care and comfort. However, it appeared that the nurses

used specific drug focused interventions in many cases rather than a comprehensive suite of interventions.

*Anyhow, **pharmacological intervention is used the most, I think... [we] provide it a lot. [And also] make their position comfortable... [but] the most used is anyhow medicine. Particularly, I think we give out medicines a lot when the patient complains [of pain], because the patient wants it ...*** (Youngsook TL11).

Non-opioid analgesics and/or opioid analgesics were in use either regularly or PRN.

*If the pain is not controlled with **regular meds**, there would be a prescription for a **short-acting [opioid] analgesic as a PRN** with maximum dose. If there is such an order, we go and get the med and give it to the patient every time [patients complain of pain]* (Jina TM12).

***Most [of the patients] have it [opioid analgesic] regularly.** I mean the patients who are in their early stage of cancer may not complain of much pain, but once their stage [of cancer] progressed, they may [ask for opioid analgesics] or if they are hospitalised for pain as a chief complaint, they are admitted with a prescription for it [opioid analgesic] as a regular med... (Jina TC9).*

Not always, but in a few cases, a placebo was used to manage pain in the study setting.

Youngsook experienced the effectiveness of placebos in some cases; especially if the pain was believed to be related more to a psychological dimension

*... it seems like that **the patients who were deemed to be psychologically [wanting to have more analgesics - the pain was due to psychological cause, such as anxiety] would have [more] effects [when we give a placebo], but the patients who really have pain, well there are cases that [the placebo] didn't work*** (Youngsook TL12).

Despite the active use of different analgesics, there seemed to be some difficulty in immediately obtaining those opioid analgesics. Given there was only one hospital pharmacy in the basement, patients with unexpected pain would not receive an immediate intervention, although a pharmacological approach was the primary intervention in the setting.

***It would be good, if we could get [the opioid analgesia] right away [at all times], but because someone needs to go and get it [from the pharmacy, it takes time].** If an Assistant Nurse goes and gets it, it would take about 10 to 15 minutes minimum; because she needs to go down to get it... **If it was a bit closer or there was a pharmacy on the ward, there would be no need for the concept of prep.** Even without PRN or prep, we could go and get [opioid analgesia] right away, but because it's not possible and there is a limitation to manage [opioid analgesia] on the ward, we do it like this* (Jina TC20).

Given the difficulty of immediate supply of opioid analgesics due to the distance from the pharmacy, nurses seemed to find an alternative, using 'Prep', which was an extra PRN dose of opioid analgesic that they obtained on the unit and used for breakthrough pain.

*Usually, there is **a verbal agreement among the doctors on the [each] patient who already has pain in this ward.** 'When [a patient is] in pain, Prep [prepare for/ preparation of] immediate released IR codone or Actic or Morphine to give and how much mg [to give]' (Miho).*

*There could be **Prep or something similar to PRN** for controlling breakthrough pain, otherwise there could be regular analgesic order (Jina).*

There seemed to be more obstacles for the intermittent use of opioid analgesics due to the regulations within the study setting.

*In fact, there **is a code for PRN order.** So, when pain is over certain score, we can give PRN, but **I don't think it is the same in opioid analgesic [opioid analgesic can't be prescribed as PRN], so I think we have to get an order for an opioid each time [from doctors].** If a patient has frequent pain really, we might do one more dose as a Prep. And so we do one more Prep and we can give it right away when [the patient] has pain [but we can't do the same for the patients with less frequent pain] (Nari).*

It was clearly written in the NTGB that 'opioid analgesic for oral or transdermal use for the in-patient cannot exceed one day's worth' and 'all injectable opioid analgesics should be received and administered at ordered time'. With this hospital regulation, any routine opioid analgesic could be stored in a locked safe on each ward for a day, but the nurses seemed to have trouble with immediate use of opioid analgesic, if it was prescribed as initial or occasional PRN use. Even the nurses seemed to view 'obtain Prep' as an acceptable practice in the study setting, which meant the nurses saved some PRN dose of opioid analgesics for a day, if the patient needed a regular dose of PRN opioid analgesic.

2.3.2. Non-pharmacological interventions: Limited use

There were some cases when the participant nurses witnessed the effectiveness of non-pharmacological interventions as Kyoungmi noted: to **have a conversation with them,**

talk to them and hold their hands, they sometimes say **it gets better** (TL63) and Jina reported

*... some volunteers come to provide **foot massage** for those patients who have been referred for hospice care. **They [patients] say they like it very much**. On the day... the volunteers have visited, **I can see different facial expression and the patients look absolutely comfortable**. In a situation like this, I think doing massage and having chats [with patient] could be much better in managing pain than giving medicine (Jina TL63).*

Younhee (TL63) described non-pharmacological interventions that enhanced the effectiveness of drugs and actually provided the patients with more comfort. ... *when the pain is not controlled [well] with the [pharmacological interventions], **you can get 100% of effect by adding non-pharmacological interventions***.

Miho (TM11) said

***I just give them pharmacological interventions and plus [sometimes use some non-pharmacological]**. For example, I've applied a **hot pack**, when a patient complained of abdominal pain, **but I haven't done it a lot...** Otherwise, well, I do say "**Relaxation therapy...**" "**Take deep breathing**", but **I don't just do it [non-pharmacological] alone**.*

Although there appeared to be some evidence of preference for their use, non-pharmacological interventions often seemed to be recognised as less valuable interventions among the participant nurses.

2.3.3. Influential factors on decision-making

While there seemed to be a level of agreement on the value of **using** non-pharmacological interventions there were also a few influential factors on how the participant nurses make decisions in terms of choices of interventions, **especially on active use of non-pharmacological interventions along with pharmacological interventions**.

2.3.3.1. Excessive workload limiting quality nursing care

Jina reflected on her thoughts on providing non-pharmacological interventions. Unlike the initial response regarding these, about which she did not seem to be confident, she stated that she learned about non-pharmacological interventions at some level as a nursing student and it would be possible for her to use them, if she wanted to. She said it would not be too hard for her to use them, but she did not have enough time to sit at the bedside to do this. She reported excessive workload that limited chances of offering quality nursing care

... we've learnt about it [non-pharmacological interventions] quite a bit as a nursing student and you can learn and you can use as much as you want to, if you are willing to. I don't think it's really difficult, but because I don't have enough time (Jina TC25).

Nurses maintained knowledge and skills for use of different interventions obtained elsewhere.

*I've done [hand acupuncture] only once since I left school. Yes, hand acupuncture... **there was such a subject...** But, **I don't remember it, because I haven't used it.** I've also had a certificate on foot massage, but I don't remember anything... Because there is no time I can use it (Jinhee TC16).*

It was observed during the participant observation that RNs, including Jina, clearly spent a lot of time on data entry and computer orientated tasks. She checked new orders and entered data on each patient's EMR. She sometimes printed out an additional medication card and wrote a couple of patient name on a sticker for X-ray then stuck these on the bench bar in front of her seat. The staff seemed quite busy with completion of routine tasks.

The participants had limited time for hands on care given the excessive workloads frequently raised in the previous themes; interventions that were less time consuming such as a quick verbal instruction and use of analgesics would be the easier choices for them. It was clear during the EMR review that '*administered a prescribed medication*' was the most common intervention used as the intervention for managing pain followed

by ‘encouraged verbal expression of pain’. Jina’s and Jeongmi’s perceptions of tasks to be achieved during the shift over-rode a focus on pain management.

*I think it is also **difficult [for the nurses to use different non-pharmacological interventions]**. Rather we say “Lie in your bed.” **[If a patient says] “I’ve got pain in my legs as they are swollen”, I say “You better lie on your bed and lift your legs up”, providing a pillow.** I would say “If you lie down and the swelling goes down, your pain will get better. **I’ll bring a pain killer as soon as it’s prescribed.**” I would do this much, but **I wouldn’t say “I’ll do warm massage” or “I’ll do some massage [for you]”, because of a lack of time...** (Jina TM21).*

*I mean, it seems that **analgesics are the most powerful method to decrease pain**, I think. When the patients feel like **they could be dead because of pain**, **[you can’t just say] ‘You should relax or use relaxation therapy.’** I think it **rather has a greater effect when you have analgesics than trying to change your mood or redirect the thought.** You can see its effect when you have an analgesic... **It decreases [the pain] in 15 minutes after injection...** I think that’s the best thing about it (Jeongmi TL11).*

The nurses often reported that they did not have enough time to interact with patients, in a way that would establish therapeutic relationships and the collection of relevant information. Therefore, nurses could miss the chance of gaining more information to achieve meaningful assessment that would be fundamental in making meaningful decisions.

*... **we visit patients several times** including visits **[for checking] vital signs**, but **it doesn’t mean that we frequently talk to [communicate with] the patients**, honestly. We usually talk with the patients during the regular rounding, but **the registrars or the professors [consultants] come in at different times than ours and take a longer time to interview the patients...** (Jina, A-III-4).*

While the doctors had more details from which to assess patients, nurses appeared to consider their inadequate attendance when caring for the patients as due to time limits; they saw this as one situation that they could not avoid or change:

*RN Jina received handover from the morning RN for her **15 patients (she had 18 beds in total for the shift)** (A-I-7) and Eunsoo argued that*

*Just the shift itself **[routine tasks to complete make me busy] too many surgeries, admissions, [receiving] post-op patients, [receiving] new admissions and making discharges and solving issues** when patients make complaints (Eunsoo B-VII-4).*

Jina (A-III-5) said they were unable to attend adequate assessment and that they were

... often missing it [pain on motion], because the patient says “I don’t have any pain, if I don’t move, but I’ve got pain when walking... also the patients tended to avoid certain situations that caused pain such as walking without saying it [reporting the pain when it happens], so it is hard.

Miho (F-VII-2) noted when a need arose for patient tests or taking samples for lab tests that she

... may take a shorter time to visit patients... To be honest there were some occasions that I don’t even ask [whether they were OK], if the patients look alright. // ... because I still have many things that I have to do, I feel rushed, so when I go and talk to the patients, even if I could use... two to three sentences, I only use one sentence.

Besides nurses’ perceptions of time limits and attitudes towards pharmacological and non-pharmacological interventions, they also held assumptions about patients’ attitudes towards those interventions.

2.3.3.2. Nurses’ attitudes and assumptions

The participants appeared to consider pharmacological interventions were scientifically proven; hence, they were superior

... because they haven’t been [scientifically] proven [of its effectiveness] yet, I can’t competently recommend non-pharmacological interventions, ... because pharmacological interventions have been proved and you can see their effect, pharmacological interventions are used as the first choice. Because you can see the effect and your body reacts right away, and I think it is objective. Non-pharmacological interventions like massage, hot pack and things like that are not objective [scientific] (Eunah TL33).

Nurses seemed to make assumptions; they believed the patients would not want to have non-pharmacological interventions; because these would usually take longer to show effect when compared to pharmacological interventions.

I don’t think [the patients] would want to [use non-pharmacological interventions]. [Patients would] like the [interventions] that have immediate effect... but relaxation therapy... I think it takes... a bit of time... like... [it doesn’t have] an effect that the patients can feel, it doesn’t have a huge [effect that they can] physically feel... (Jinhee TL34).

In other words, Miho and Eunah considered non-pharmacological interventions as ‘extra care’ that they might provide, when the patients or the family caregivers asked for these; or as a way of buying some time when they could not provide immediate pharmacological interventions.

[Extra care, non-pharmacological] is provided when there is a request [from patients]. It doesn't seem like we provide extra care without request ... (Eunah TL35).

*I don't think it [non-pharmacological interventions] can take 100% pain away. I mean, **it's helping you to buy some time*** (Miho TM20).

*Although I use [non-pharmacological interventions], **[I only use these], if I can't give them analgesics**, otherwise I'd use analgesics most times* (Miho TM20).

The researcher's observation was that the nurses' attitudes might have been impacted by the organisation's requirements for retrieval of costs associated with care provision.

2.3.3.3. Non-redeemable nursing activities

Along with a lack of human and material resources in providing a variety of quality interventions for managing cancer pain, the situation that most non-pharmacological interventions were not considered as items attracting fee charges appeared to negatively impact on nurses' decision to use different interventions. The organisation would not be paid for that type of nursing care provided, even if they provided time-consuming care and recorded what they did.

*There are **some actions that we consider as a nursing** [service that] can be charged fees to the patient such as administering medications, ... But things like **applying hot pack and massage can't be calculated into fees to charge**. ... That's why nurses use medications... because it is hard to calculate into fees [on non-pharmacological intervention] considering how long you spend with patients. ... you don't get recognition from the hospital* (Eunah TC15)

There were important influential factors impacting on nurses' decision-making including excessive workload that limited the chance of quality nursing care and diminished knowledge and skills due to minimum use of alternative to drugs; nurses' attitudes towards pharmacological and non-pharmacological interventions, assumptions about the

patients' attitudes towards those interventions; and inability to claim for payment of nursing activities.

2.3.3.4. Lack of patient education on pain management

The participant nurses seemed to provide relevant information during their routine care for those patients with cancer. For example, Nari (TM 10) described how she educated patients about the use of pain management devices, when they came back from surgery with a PCA ... we say, ***"This is a PCA that is infusing [analgesics] and it will give you medication [analgesic] many times per day."***

Eunsoo (TM10) also corrected the patients' misconceptions giving them explanations ... *[I say] that [taking analgesic delays recovery] is not true, so they better take analgesics, if they are in pain. Holding off pain wouldn't help recovery.*

However, even the few booklets for patients that they had, containing pain management related information, did not seem to be consistently used in actual practice for the purpose of patient education on many occasions. For example, a patient information booklet, 'Pain Among Patients with Cancer can be Controlled', published by the MHW, seemed to be used only during the accreditation period, but was not used during periods of participant observation.

In fact, we have pain management information booklets in the ward ... [I mean] there was a booklet called 'Cancer patients' [Pain Among Patients with Cancer can be Controlled]'. So, we gave it out for the patients and provided education for a while [during the accreditation], but at the moment, because we are so busy, we can't do as much [as we did during that time]... (Miho).

Patients' ability to report on their own pain without any misconception about pain and its management would be a fundamental part of optimising pain management, and ongoing regular patient education would be prerequisite to achieve such ability. Despite the clear

need for education in the organisation, it was not evident that patient education was well organised and was provided for those patients with cancer who were experiencing pain.

*No. There was **no such thing [providing systematic patient education]**. In the hospital or even in the ward, there was **no patient education** that was done... to be honest... (Miho F-V-1).*

Collaborative education for both nurses and patients would be an important way to achieve a 'nurse patient partnership' practice culture.

2.3.3.5. Inadequate education for nurses on pain management

It appeared that the nurses were receiving pain management education as a part of cancer care or as a part of general nursing care. The nurses however did not appear to prioritise pain management as important contents that they needed to know as they did not consider their patients were in much pain.

*We do have **an education session on terminal cancer patient management [that includes pain management] every year**. There are **surgical nursing and medical nursing [sessions] for the adults once a year**. When they cover issues about medication, they cover analgesics, and post-op analgesia is covered during the surgical nursing. //... if the ward is full of terminal cancer patients, the nurses would have more interest, because they have to deal with such issues. But **our ward is mostly acute stage patients and there might be one patient [with pain] in all the patients that I have to deal with**. I think this is why we don't feel much needs. // I think **nurses learn things, because they need it** and they need to know it to take care of patients. ... It [cancer pain management education] wouldn't be needed in the neurology ward or other wards, would it? So, **the wards where they look after cancer patients especially advanced cancer patients**, who have more serious condition [including severe pain, need such education] (Eunah).*

Jinhee stated that nurses had pain management related education as new graduate nurses as part of the orientation, but this education did not seem to be continuously reinforced. Nurses used 'NTGB' that included some pain management content in order to provide care and maintain record on pain management, but Jinhee only remembered some details of the content.

*We do have a guidebook [NTGB to train the new graduates]... because they have to do nursing documentation, **they all learn about things including that [pain management during the orientation period]**. // ... it [NTGB] has **content about***

pain assessment tool... something like do what in different ages [how nurses should assess pain for the patients in different age groups] with a pain assessment tool... and use a certain assessment tool for the patients who can't speak... (Jinhee).

Nari's report on pain management education indicated that the education on pain management was provided without the reflection of nurses' need of education and/or the current nursing practice of cancer pain management.

... we don't have education for pain management a lot. Indeed, even the education [that we have] is like 'Because the JCI manage pain like this, so [we should] do like this and that' (Nari I-VII-5).

Jinhee also stated that there were some regular personal development education sessions or conferences, which nurses had to attend in the hospital. These included some pain management related topics such as relaxation therapy including massage and foot massage, but Jinhee said she never applied what she had learned to her practice, and thus forgot how to use the different non-pharmacological interventions. This illustrated that even the education the nurses were provided did not progress into changing their practice, given the busy workload.

During the conference, we have set topics for a year... [so] during that time we learn about relaxation therapy that reduces pain... We've learned about how to massage... and talked about foot massage... // But I've never used it. Because I don't have time... (Jinhee).

Jinhee emphasised that she would not want to attend any of the education sessions, even if there were any regular programs about non-pharmacological interventions, because they would not be used in practice. She described the current education programs that were run by the nursing department in a negative way. It seemed she thought these to be ineffective and she was inattentive because the programs were usually run in the afternoon and the morning nurses had to attend the program, where they would be dozing off. Also, because pharmacological interventions were the general measurement for cancer pain management she did not intend to use alternatives. Jinhee

later expressed her concerns about her practice; she recognised how differently she practiced compared to how she thought about nursing when she was a nursing student.

[I have to] do as it has been ordered... it feels a lot like I'm a kind of a machine, because I've got too many things that I have to do and I have to complete them in time, I've got no enough time for them, I hardly have time to contact [be] with the patients [at the bedsides]... I attend the patients [where I am allocated]... // well ... when [patients are in] pain, I give them analgesics... [if patients] say [request] something, I do that... I only do what the patients request, but I can't do things much on my own [independently find issues and provide cares, if there is no request] (Jinhee).

From the emergent themes from observations and interview data, it appeared both the nurses and the patients needed meaningful regular and ongoing education for improving cancer pain management. Despite the needs of both parties, these did not seem to be met in the study setting.

Theme 2.4. Evaluation of nursing actions: Guess work and minimal practice

Absence of actual attendance for evaluation at the bedside reportedly due to busyness seemed to be part of usual practice. The nurses provided interventions without adequate evaluation

... there are times that I can't ask because I'm busy... actually there are times I missed asking the patient [if the pain has been improved] (Eunsoo B-V-II).

The 'NTGB' gave a brief direction to nurses in terms of pain evaluation. Therefore, the nurses were required to evaluate the effectiveness of given medication to manage pain in an hour, if it was not the regular ongoing medication. Nari noted she needed to obtain routine mandatory assessment and considered it as the evaluation for those patients who were on ongoing analgesics

... we do the regular evaluations on pain, but...[maybe not comprehensively]. It is mandatory to do so in EMR ... (Nari) and Eunah said I would revisit the patient in about 30 minute if they had injection for analgesics, because it works faster, but if s/he had oral meds, I would go in an hour (TL13).

Some participant nurses seemed to follow the guidebook, but others confessed that there were times that they missed physically visiting patients to evaluate the level of patients' pain after providing interventions. This could indicate that nursing practice for managing pain for patients with cancer became insensitive in terms of a continuum of care; they were not strategic about their care processes.

*It is the policy in the hospital that we have [direct us] to evaluate the patient in an hour, but **it's not followed well**. But **if the patient doesn't make a complaint again, we take it as the analgesic was working well** (Jeongmi TL13).*

Some nurses had an expectation of patients' further reports of pain, if the chosen interventions did not lead to a satisfactory outcome rather than evaluating the outcome of the intervention actively by themselves. This could limit nurses' more active involvement in assessment and evaluation of pain; they seemed to take the option of passive practice behaviours.

*Anyway, **the patient would come and report pain later, if the patient is still in pain despite the analgesic**. [They would come and say] "Well, although I had a pain killer, I'm still in pain. Give me more pain killer again." It could be like this or **otherwise the patient won't say anything** (Eunsoo TL15).*

The participant nurses' passive approach on evaluating pain was formally recorded as 'no further action taken' when the nurses could/did not see or have reports on the changes in patients' behaviour. This could limit chances of accurate pain assessment regularly on each shift, as it was quite common for the patients with cancer who were experiencing pain to hold off reporting their pain without any expression of discomfort.

Theme 2.5. The dynamics: Family, MO and the nurse

The family, the MO and the nurse are central to making decisions in managing cancer pain. The interactions between family, MOs and the nurse sometimes have a positive influence on patient care, but more often it resulted in a negative impact.

2.5.1. Family: Helpful/unhelpful

Family members could be both helpful and/or unhelpful in terms of caring for patients with cancer who are experiencing pain. Where the family members were still quite close to each other, they were involved in caring for patients. Nurses often turned to the family caregivers for information that might help the nurse to assess the pain of the patients in their care. Nurses noted that patients were often reluctant to report their pain and discomfort.

*I think the patient must be in pain, but s/he doesn't say. [In this case, if] **the family caregiver says** [what the patient was usually like], it is helpful (Eunah TL58).*

Nurses approached family caregivers to know more about the patients before posing direct questions to the patients. The information provided could be helpful in understanding the patients and their condition better and that would ensure the conducting of appropriate assessment.

*For **those patients who seem to be extra sensitive [impulsive/easy to be aggressive]** even with questions that I ask [to assess pain], it can be a bit [difficult] to approach them hastily, so **I ask carers how the patients usually talk [express themselves]** "Has the patient been OK today?" (Jina TM9).*

As expected in Korean culture, it is common to see that at least one family member or a paid personal carer stays at the bedside through the patients' hospitalisation and involves him/herself in basic care of their loved one. Family, for example, assist with meals and hygiene, and even provide massage when the patients are in pain and/or discomfort, when the pharmacological interventions could not be given immediately.

*In a situation like this [a patient is complaining of pain, but doctors are not contactable], I go to the patient and verbally do it [explain the situation or verbally calm down/ comfort the patient] or **ask the carer to give some massage for the patient** (Jina TM27).*

However, there were cases where the family members could be unhelpful in providing care for the patients. During a conversation with the nursing team of Eunah over lunch about a patient with fungating breast cancer, Eunah indicated that the family members'

responses to the nurses were preventing the nurses from having a good therapeutic relationship with the patient. Nurses were uncomfortable completing their duties for the patient, when there was a family member staring at the nurses with an apparent coercive attitude.

*During the participant observation, Eunah asked me to go to have lunch in the staff restaurant with three other RNs. Once we took a seat, she started asking about a 52 year old breast cancer patient, Malsoon. **Malsoon was found at home with fungating breast cancer by a social worker.** When she was transferred into the hospital for the first time, her Hb [haemoglobin] was 2.6 due to continuous bleeding from the cancer wound [so she had to have blood transfusion]. On that morning [of the participant observation], she had [another] 2pints of Red Blood Cells and Hb came up to 7.6 from 7.0. Malsoon had **a husband with a history of domestic violence** and a son on board a fishing vessel to earn money for the mother's treatment. The RNs said **they did not feel comfortable when the son visited his mother, because whenever any RNs went into the room to ask something [to assess/check on her], he reacted with defensive behaviour by showing a coercive attitude and very protective responses [as if the nurses would harm his mother]** (Field notes: Eunah).*

A family member's personal faith appeared to influence making treatment decisions, especially if s/he was the primary decision maker, for example, if the family member was a believer of a certain religion and/or cult, which tends to have different approaches to treat diseases without assistance from the healthcare system. The chance of the patient receiving adequate treatment can be decreased in this circumstance.

*Eunah briefly talked about another patient's case during interview; **she could not have initial treatment of cancer [or any symptom management including pain], because of her husband's weird religion [false religion and/or cult that rather supported religious rituals instead of medical treatment]. The patient was left at home without adequate treatment and now there was nothing that they could offer except pain management** (Field notes: Eunah).*

Nari shared her experience of a family member's aggressiveness, when he had a lack of understanding about the patient's progress/situation. Not every family member would have the same level of understanding about a patient's progress, particularly when they did not have a regular contact with and/or visit the patient, but there was a rapid change in the patient's progress. It could be a more critical and sensitive time for healthcare

professionals including MOs and nurses to place the patient/family in the centre of care to meet their true needs, rather than just completing the given tasks

*... because **she [a patient] had deteriorated a lot**, we moved her into a single room. After we moved the patient, **the family members who I had never seen** to come and visit her before, came in. The patient was able to verbally express her pain before [when the families came to see her previously], but **from that time, verbal communication became difficult**. So, because the patient expressed [her pain] with her facial expression, her family... I think **it was her elder brother**... Anyway, I don't know if he [the brother] didn't have a good relationship with her husband, but [anyway] he hadn't come [until that day], but **came for the first time and became aggressive as he saw his sister was in a great pain**. So, [the brother] requested to put up an analgesic quickly, [we] notified [the doctor]. So, **her doctor came, but [he said] he needed to get DNR [permission for 'Do Not Resuscitate' instead of writing up an analgesic order that the family requested]**. The doctor had [obtained] a verbal [DNR permission] before [from the patient], but **now because the doctor was trying to explain to get [written DNR permission as the patient was quickly deteriorating], her brother couldn't accept it**. Because they've seen her [deteriorated] condition for the first time... **They were in a difficult situation and becoming fussy... and eventually we hung [analgesic mixed fluid] up** (Nari).*

Unmet needs amongst patients or family members because of any inadequate level of interventions including a lack of comprehensive explanation and updates about progress of patients, and an insensitive approach when health professionals including nurses made decisions about patient need themselves without including the patient or family appeared to cause/escalate the aggressive behaviour of patients or family members.

2.5.2. Medical hierarchy and medical dominance

There seemed to be a hierarchical relationship and dominance of medical authority among the healthcare professionals; this marked the boundaries within which nurses should practise, and it was also embraced/accepted by patients and families. The hierarchical structure in decision-making processes among the same group of healthcare professionals and/or between different healthcare professionals seemed to cause barriers in terms of communication and hence in meaningful changes in the whole healthcare system. Although the CPMG suggested that *'Cancer pain needs to be assessed and interventions to be provided by those multidisciplinary healthcare*

professionals who are involved in pain management', there did not seem to be active voices from different healthcare professionals such as nurses. The situation was rather reflecting more top-down communication patterns.

Even if I think it would be good [for the patients] to experience hospice care [for the purpose of receiving better interventions for pain management], even in our hospital, that means changing the professor [transferring the patient under the consultant who has specialised in hospice], so it still can be a really sensitive issue.... (Younhee E-IX-3).

It appeared that the medical consultants who was responsible for the patient had the final say on decision-making in relation to pain management in this setting. This reinforced the notion of a hierarchy of healthcare professionals with medical consultants having ultimate authority over pain treatment and created difficulties for a 'nursing presence'. The medical consultants would be recognised as the most specialised in terms of treating patients in their own specialty and hence they seemed to lead the treating team by making the final decisions for treating the patients. This could make it more difficult for nurses to express their ideas/opinions about relieving pain amongst the patients in their care and/or giving feedback on the patients' responses to pain.

While they [the doctors] were on their rounding, I talked to [a registrar] to ask [a professor] to give some analgesics, because the patient was in pain. I do this often [I only request registrars to receive order from consultants for prescribing analgesic] to change orders. But because they [patients] were 'the professors' patients', it was not my place [to mention what to do, in terms of making the decision on treatment direction] when it comes to talk about transferring the patients to the hospice care [I had no right to say what to do, so I can't go any further even though I think the patient would benefit from having a hospice care for adequate pain management] ... (Younhee E-IX-2).

Many nurses avoided what they referred to as overstepping their role as a nurse or the MOs' authority by suggesting alternative approaches to relieving the pain of their patients based on the response of the patient to prescribed analgesic approaches. Many of these nurses also wrestled with what was best for the patient and their obligation to advocate for them.

[I want to say more firmly to doctors that non-opioid analgesic wouldn't work for patients from my experiences of patients, thus we better give them stronger analgesic]. But, there are people who think it was overstepping the doctor's

authority... Also, I just believed that they [doctors] would know better than me, because they've learned more than me... If I think of it, I think it could be overstepping, if I think about it objectively. But, in my subjective thought, I also think I should say things that I have to say. (Kyoungmi TC24).

The participant nurses appeared to have great hesitation in directly talking to the MOs, especially the consultants, but sought someone, whom they felt more comfortable with, in order to express any personal queries or requests.

Because we are closer to the NPs [Nurse Practitioners], we talk to them, because they act like a mediator between the professor and us... But they may not be able to comfortably talk to the professors [consultants] either... // It's still a little bit like nurses shouldn't make comment on [doctors'] treatment plan. There is such a perception... (Younhee E-VII-1).

However, the role of NPs was more about replacing the MOs where a shortage occurred, especially the juniors, therefore their responses to medical consultants appeared to be similar to those of junior MOs.

They [the NPs] usually do dressings... it's a bit funny, but they do dressings, and go for rounding with the doctors. Then... yes they go for rounding with professors, and then something like organising [summarising] discharge charts, if any patients are to be discharged. Also, they do patient education. Something like wound care and stoma care education... (Eunsoo).

Furthermore, some MOs' communications were observed to be commanding or directive rather than communicative and thus nurses hesitated to express their concerns for the patient and check a prescription, which might have been meaningful in terms of understanding the patients and improving patient outcomes.

Even, when I asked for confirming an order, [the doctor] said "Do it as ordered." It's a bit like... although he was a doctor, because we've got more nursing experience, we feel there was something wrong, [but] he just said "Isn't there an order? Do it as ordered" (Jinhee C-IX-1).

Nurses tended to follow orders regardless of their own concerns about what might be needed for the patients. Kyoungmi shared how she responded when a MO wanted to try a weaker analgesic that was prescribed but she neither agreed on the decision or reasons for changes.

Even though the patient's pain is continued, because the doctors think that the patient uses too much opioid analgesic, they changed [the current analgesic] to a weaker analgesic... [I come to think] "Well, this is not right..." or "Well, wouldn't s/he say s/he's still in pain? [I think s/he would]" ... 100 out of 100 would say they're still in pain, although we give [this weaker analgesic instead of the one they were on] like this... I feel frustrated. // Yes, [we still just follow doctor's orders] (Kyoungmi).

Along with Kyoungmi's frustration, when she had to follow the order she did not agree with, she further described how she made an alternative decision to accommodate the order, but avoid conflict with the MO. This clearly showed an ineffective way of spending time among the nurses, who already struggled with time constraints due to excessive workload.

We, the nurses as the one providing nursing care [at the bedside], we feel it is difficult and the patient would feel difficult, so, we think it is not right [that we can't express our opinion, because it can be considered as overstepping the doctor's authority]. But we have limitations in rights of claiming [our own opinion] so strongly. I can't just say "Let's give IR Codone" or like "Let's give Mypol" like this... So, it ends up there like that [it ends up that I am not speaking out about own opinion]. Instead, we quickly provide [whatever] the intervention [that the doctor ordered] and say "It didn't work. [It didn't make the pain] subside. You better give another order quickly" (Kyoungmi).

Medically hierarchical and dominant practice obviously limited nursing practice and hence negatively impacted on the patient outcomes. For example, the nurses reported and were observed to look for the MOs' authority before they administered a previously prescribed PRN analgesia order. Nurses seemed reluctant to make their own clinical decision to administer a PRN. Patients suffered unnecessary pain as a result, because nurses did not take immediate action.

Again, there seemed to be a level of frustration around what they perceived were shortcomings in their practices. As already shown, Kyoungmi expressed her thoughts, and the nurses experienced concerns around maintaining silence; they knew what they should do to advocate for the patient among the team of healthcare professionals. However, because of the hierarchical/vertical working culture and the Korean notion of "the virtue of indirect expression of self", sometimes nurses were reluctant to advocate

for patients and express their concerns with the consultant. Consequently, they considered making surreptitious suggestions to the patients that they should directly ask the MOs for “hospice level care” in order to receive adequate level of care to relieve their pain as an alternative way of advocating

... because I have my own thought, when I can't stand it anymore and I feel frustrated [because patients have been getting inadequate pain management for some time] // ... I would talk to the patients secretly [secretly informed the patients about hospice care, if I really want to] (Younhee TC23).

Additionally, there seemed to be some patients' contributing to strengthening the hierarchical relationship between different healthcare professionals by showing preferences for MOs over nurses. Jinhee (C-IX-4) suggested this could be due to the embedded hierarchy and values in the higher educational background in Korean society ***[Patients often treat us] differently... They seem, sometimes, against us, [if we say something], but when doctors come and say the same thing, they easily take it.***

Behaviours demonstrating influences of hierarchical relationships in the healthcare system were not only seen between different healthcare professionals, doctors and nurses, but also among nurses.

2.5.3. Desire and reality: The dilemma for nurses

In this particular study, nurses were central to decision-making; the study focused on the nursing practice in managing pain. It was noted that there were dilemmas that nurses encountered between their personal desires for one approach to practice and the actual practice mandated for cancer pain management. Nurses were influencing each other through their intra professional relationships, when they made decisions.

Nurses wanted to see their patients with little or no pain, because they acknowledged its negative influence on patient outcomes. Nurses' own professional responsibility and accountability to drive or influence nursing practice of pain management was noted.

Eunah highlighted reasons they endeavoured to manage pain among patients with cancer:

I personally believe that it is not right [good for the patients] to hold back pain while they are hospitalised (Eunah TL59) and Kyoungmi expressed similar views.

*Firstly, **I don't like the patients to be in pain... Just I feel that way as a nurse. And I think pain management is the most important activity in a day [as daily duty], because patients have different attitudes, depends on whether they have pain or not... The patients with pain wouldn't want to follow the treatment well and seemed to be bothered... like 'what's the point doing it [following treatment]'**, they think like this... so I think pain management is important* (Kyoungmi TL60).

Despite situational challenges in nursing practice, the nurses still recognised the value of some nursing elements in terms of caring the patients. As Jeongmi stated, establishing a good therapeutic relationship with patients could increase the chance of understanding the patients better and thus improve nurses' confidence in their practice and acting as a part of care teams

... if there are patients who I have a good rapport with, those patients open themselves comfortably to us ... they tell us when they had discomfort at home, when they had pain... while they had activities outside and things like this. I feel comfortable providing nursing care or making suggestions to doctors [if I know the problem better] (TL55).

While medical hierarchy and dominance were part of the dynamics that nurses needed to work with in their practice, nurses' desire for a meaningful professional response was also noted in their willingness to care for patients using the concepts of nursing rather than just following the orders of MOs. Jina shared her thoughts on what she considered as important among her roles as an experienced nurse.

*I started thinking about **distinctive areas of nursing** although I still thought not making an error was a very important thing. **Things that nurses could do as nurses. It didn't have to be drug involved or treatment related...** Nursing skills that I had learnt as an undergraduate student... **Verbally establishing a rapport can be one... Actually you can sedate your patient verbally [You can comfort your patient with verbal intervention], actually relaxing therapy, actually all those things you know. Things far from direct [medical] treatment. Exceptional things that can't be pharmacologically covered... complementary therapy or something like that*** (Jina TL54).

On some occasions, the nurses demonstrated the therapeutic knowledge and relationship with patients, as they were to be able to converse with other healthcare professionals about patient care as a member of the healthcare team and practice as a competent healthcare professional. For example, the participant nurses relied on interventions that they could use within their scope of practice such as verbally comforting the patients and/ or asking the carer to massage the spot where the patients reported as painful.

If the doctors are in conferences or have gone out [so they are not contactable], there is no way [to proceed]. In a situation like this, I go next to the patient and verbally do it [explain the situation or comfort the patient] or ask the carer to give some massage for the patient. There's no other way [this is all I can do]... (Jina TM24).

While there was an understanding and desire to deliver meaningful professional responses to pain experiences of patients, in reality, it was not an uncommon practice for those participant nurses to report to the MOs immediately when patients made complaints of being in pain, even without visiting the patients to obtain adequate assessments on the pain including the nature, location, patterns and severity. Jina (TL 44) said *I would rather notify the doctors [right away], so they can give some medication or something to the patients....*

This was a typical example of the outcome of nurses' dilemma between their desires and the reality of the practice environment. It was interesting to note how nurses internalised the outcomes that did not reflect their professional desires. The nurses did not seem to consider the practices and interventions within their scope of practice as valuable parts of the whole treatment and as an effective way of caring. They rather seemed to value only MOs' prescription of analgesics. This could indicate their view that the whole scope of nursing practice was dependent on medical direction and limited to that of supporting medical teams. Miho said ... ***with medication... I feel like I've provided some interventions and also the patients feel that they've got some interventions*** (F-I-2)

Younhee pointed out that having no rights to prescribe medication including analgesics was the barrier to providing optimal care amongst the patients with cancer. This could be an indication of a belief that pharmacological interventions are the only option for managing pain amongst the patients with cancer, and hence the reason for only valuing MOs' decisions

... if the doctors say they're not going to prescribe it [the analgesic I think would work], then that's the end of the story [as there is nothing I can do] I mean, it is out of my control... [it's] a problem that is beyond my rights. So, it's difficult when I have to do pain management. The fact that I don't have the right to make decisions (Younhee TC23).

The dilemma apparently prompted some participants to recognise a need for changes in their practice in their own minds, but they did not appear to progress to actual changes in their own practice.

I'm not satisfied [with the current pain management strategy]... but because it [the way we practice] suits the current situation, so I have to keep it. As I said before, it feels like I become a machine... bit like that... but, this is the simplest way, so I'm comfortable with it... (Jinhee C-IX-17).

Alternative options were abandoned because of their own rationalisation of the need to maintain the 'status quo'.

2.5.4. Negative workplace behaviours among nurses

Although some participants felt uneasy discussing their concerns and opinions with managers as outlined in the previous theme, there seemed to be some level of interactive communication among nurses when they managed pain.

I can hear [from the senior] "Do it this way" "Do it that way" and I also advise the junior with some other methods, if they say they don't know well... I think we are good with it, because we work together (Youngsook J-VIII-1).

Eunah also described how new graduate nurses in her unit generally received support from the senior nurses including herself, a Charge Nurse (Clinical Nurse) and their preceptors.

They [new graduates] usually come to me [to ask questions]. But, because they do have a preceptor-preceptee [system], they also go [and talk] with them [preceptors] a lot.

However, she highlighted that she witnessed some nurses were experiencing difficulty due to the uncomfortable relationships between nurses; hence, Eunah separated those nurses by altering rosters.

There was the nurse who was scared about giving handover to this particular nurse. In a case like this [I ask the HN to] put them on the same duty [roster], so she didn't have to give or receive a handover [to/ from this particular nurse] (Eunah).

Uncomfortable relationships amongst nurses appeared to be very harsh on the persons who were victimised, particularly when two nurses were in a relationship of preceptor and preceptee. During the participant observation of Jinhee, a new graduate nurse, Hyunyi appeared to make some kind of mistake on the previous day and discomfort with senior nurses including Jinhee was observed. Jinhee described what happened with the new graduate nurse when she was asked

What did Hyunyi do? [I mean] because she made so many mistakes. // Now, I've come to the point, where I've given up [on her]// Even though I give her some homework [to do, she often doesn't complete it]... If she was willing to do it... [she would've found some way to complete them]. There are girls [nurses] who observe other people [nurses] doing things and do [perform] their [tasks] well... [but] I don't think everyone does a great job [in completing given tasks], when [preceptors] teach them a lot [including pain management]. I should teach them only few things, and they should learn things [by themselves] as they go on. It's a matter of if they cope fast or not (Jinhee).

Given such perceptions by senior nurses towards the new graduate nurses who were not performing as they were expected, some nurses seemed to accept the group behaviour of treating those new graduates in a harsh way as reasonable and part of training to become part of their nursing team. Jinhee sounded like it was very natural for her to let other senior nurses scold Hyunyi on her behalf.

I don't think I specially do anything [as a preceptor, when my preceptee doesn't perform well]... but others [nurses who work with her] peck at her... They scold [the preceptee] saying "Why can't you follow this much, although Jinhee did this much for you." // I just watch them over... (Jinhee).

Regardless of level of performance on graduating, it was observed that the new graduate nurse, Hyunyi appeared to be daunted, when the senior nurses including Jinhee called her to ask questions or to do things. Hyunyi appeared to hesitate answering the senior with a quiet and soft voice and/or hardly talking with other nurses as they were talking to each other. Such ways of training for the new graduates and nurses' attitudes towards this approach would minimise interactive communications among nurses. Hence, this could limit them working together in practice aimed at achieving optimum patient outcomes in pain management.

Theme 2.6. Roles and functions of nurses in usual practices for managing cancer pain

It was obvious that all participant nurses were performing activities around pain management at different levels of appropriateness and comprehensiveness. However, their roles and functions appeared to be limited, when they reported on their practice in managing pain.

Certain patterns of *assessment* activities were deemed necessary in the Units: **observing** the pain symptoms including monitoring behavioural changes, and **measuring** the pain using scales. Once they noticed pain amongst the patients, they seemed to go straight to the primary role of clinician by *collecting data*, asking more questions about the pain that the patient was experiencing; and *observing for further non-verbal expressions* of pain as Eunsoo said:

*When we are on rounding, their **facial expressions** are not that good, then I ask "Are you in pain?"*

However, as mentioned in 2.3.1, these assessment functions were not always comprehensive. The nurses often missed asking relevant questions to enable better understanding of their patients' pain and missed obtaining sufficient details from the EMR, which should be critical in terms of knowing the patient and her/his pain as a multidimensional phenomenon.

Once the participant nurses collected data, they would be expected to make judgements based on critical analysis of that data and even use counselling from the relevant specialist. However, the participant nurses' practice seemed to be more transactional, simply following MOs' decisions on most occasions. This could indicate that the nurses' role as researchers in looking for options from evidence based care suggestions and communicators/collectors of information for processing clinical judgements were significantly limited as Jina said.

... even though I go and listen to the patient, it is not really about what I can do, but it is up to the doctors most the time (A-VII-25).

There was no evidence of making short and long-term care plans based on the patients' care goals, and organisation of interventions as planned, once the pain issue was found. This would have enhanced the nurses' role as facilitative managers, but given the absence of a PCC concept in the study setting and limited time that the nurses could spend with each patient the whole nursing approach was more focused on superficial task resolution.

When the nurses needed to provide interventions to manage pain, only a few appeared to use some level of critical thinking skills to make adequate decisions that reflected the patient's condition. One of them was Kyoungmi who reported that

*... there is a patient who just had her operation done and has abdominal pain. I asked her "Do you have pain in the operation site?" Or **she may be full of gas in her tummy, or because she's just had operation, if her bowels haven't***

gone back to the original position that can cause pain, can't it? If [her abdomen is] filled with gas... I ask the patterns [of pain] and if it seems to be due to gas [tympanosis], I ask her to ambulate... but if she can't do it because of pain, then I give analgesic beforehand... (Kyoungmi).

There seemed to still be the latent social expectation of traditional nursing roles such as assisting MOs and nurses' acceptance of it without critical thinking about their own role or avoidance of taking responsibilities as a professional clinician as described in previous themes.

Nurses assumed a primary role of *clinician with the functions of physical and behavioural care* through preparing patients for scheduled treatments and procedures, providing interventions as directed and making observations at the outset on what they saw was the routine for care.

Drug... I gave pharmacological interventions.... Direct pharmacological interventions... And then... I continuously... [provide] emotional care, right? I talk with the patient a lot and I think it helped to reduce the patient's anxiety. Also, because she complained of pain in her flank, I applied a hot bag (Eunah).

Although there was direct admission that pharmacological interventions appeared to be their major nursing function as clinicians, there seemed to be little evidence of the nursing function of *structuring the environment* to improve patients' comfort and potentially improve the likelihood of resolving pain. Miho said "*I should make the environment [conductive to] reducing [the pain] and improving [the condition]. I think doing something like this would be important.*" Jeongmi also noted that

... during the night, when patients complain of pain, then there are environmental changes ... surrounding them, such as noise, disturbance and things like this... There are patients who say they have more pain because of such things (Jeongmi).

And Younhee said

I try to encourage the patients depending on their character, to watch TV or talk with the patients in the next bed with a lot of laughter... So, I often open the curtains [in between the beds] as well [so they can talk] ... I mean... And I encourage them to share information a lot, because I think there are fears that come from not knowing things.... And also, if there is an event [such as 'Power-up program', where patients could sing together], I encourage them to go... I

ask them to go and play [do some activities for pleasure] unless they feel unwell...
(Younhee).

The nurses' role as *educators* appeared to be taken up quite frequently, although often it seemed to be superficial and a lack of patient education was noted as presented in 2.3.3.4. There were no strategic approaches to educate the patient for pain management, but the nurses provided brief information on admission and during the hospital stay, if they recognised a need. Their main reason for education did not seem to be for rehabilitation and/or for promoting patient empowerment, but more for the patients to be able to assist nurses by answering their questions.

... when a patient is admitted, we provide a pain management information sheet and explain that the patient needs to remember the 0 to 10 pain scale and answer us, when we ask if s/he is in pain. [We also say that] they can talk to us whenever or wherever they have pain or discomfort (Miho).

It appeared that the participant nurses tended to communicate with other nurses, or with the NP, with whom they felt more comfortable, rather than with MOs. Although there were a few reports of new graduate nurses who were having trouble talking to experienced nurses, once the nurses had a certain length of experience, they usually comfortably communicated with each other to share opinions and report on the patients.

Just because we [NPs and RNs] have been [working] together for a long time, the NPs could know us better. Also, they are the one who attend to patients with their dressings and things like that, so they would know the patients better than us. So, when I say "Such and such a patient has pain here", because we can't open every single wound after a dressing has been changed, then they [NPs] talk to us "It's because the wound has been inflamed", then we go "I see." But Residents wouldn't explain things in detail (Eunsoo).

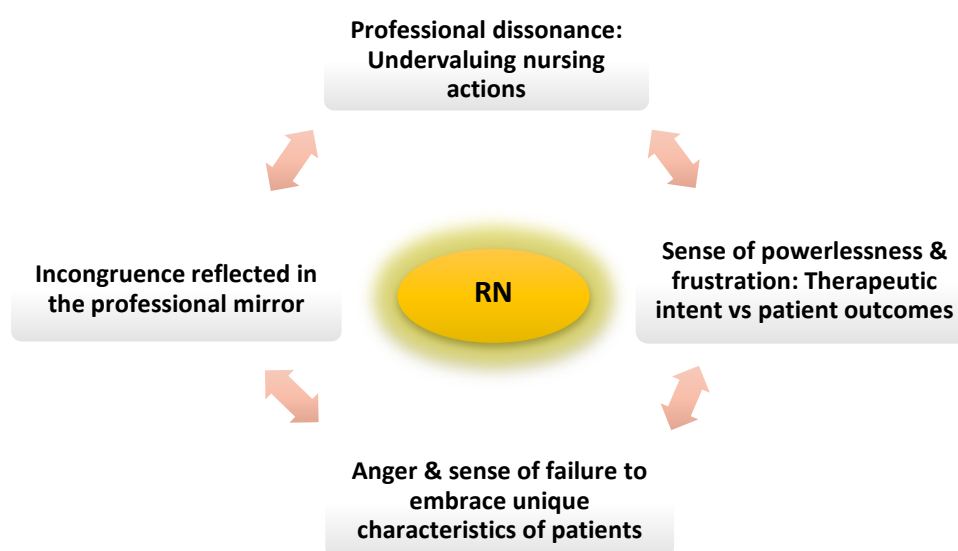
However, communications with the MOs, especially with seniors such as consultants were consciously and unconsciously restricted.

ST 3. Nurses' experiences of managing cancer pain

Ten nurses shared their experiences of caring for cancer patients who experienced pain. Patients had pain due to several different reasons, such as progression of disease,

chemotherapy and surgery. Each nurse's responses to the patients' pain varied, but there were some commonalities. The following appraisal of nurses' experiences with cancer pain management (Fig. 4.1) in the South Korean culture and context of practice could help understanding the complexities of nurses' pain management and what the nurses experienced in managing pain for those patients with cancer.

Figure 4.1. RNs' Experiences with Cancer Pain Management



Theme 3.1. Professional dissonance: Undervaluing nursing actions

As reported previously, medical dominance in nursing practice and the NTGB that guided nurses' practice in the study setting appeared to cause a great barrier in what care and how nurses could provide care within their scope of practice in managing cancer pain.

On the other hand, the nurses' attitudes towards their own practice were evidently undervalued. Kyoungmi seemed to consider pharmacological interventions as the only option to manage pain among the patients with cancer.

*I think she **had pancreatic cancer and ovary cancer**. [She had a] few different types of cancer with whole body metastases... for us, **she wasn't a common case**. Anyhow, because pancreatic cancer causes too much pain, we had a difficult time, because **her pain wasn't controlled despite the***

[pharmacological] interventions. First of all, she had chemo... and [then] surgery was done. She didn't have her surgery with us [not while she was on the ward], but she came to us after she had her surgery in another ward. [Then] she started having chemotherapy, and she had vomiting while she had chemotherapy. Also, **she had pain and her chemotherapy didn't work well.** I mean, her cancer was continuously spreading, **thus the pain was progressing,** and although **we were providing analgesic and other medications, the pain wasn't subsiding well.** Uh... **It upset me. I wanted to do something more,** but **there was a limitation what I could do** for her. // It was so sad... If there was anything that I could do, I wanted to do it, **but there were limitations in my right to give [interventions]** (Kyoungmi).

This led her to place more weight on medical approaches rather than on nursing. This also caused her to consider what she could do within her scope of practice as limited and not effective in managing pain. She elaborated upon a patient situation.

I mean we couldn't prescribe the medication, so all we could do was giving hot pack and giving a rub a little bit... and holding her hands and talking with her... And [we encouraged] to do other things... encouraged her to do something entertaining and have a chat with the patients [who were] in the next beds. Something like this... (Kyoungmi).

What Kyoungmi did sits clearly within the nursing professional terrain and should be valued as such. However, she experienced inner conflict or professional dissonance by undervaluing these nursing actions. This dissonance was also reported by Jina. When Jina thought the situation was out of her control and she did not have the power to make decisions; she seemed to be disengaged with patient care including active pain management by rationalising to herself that there was nothing more she could do, because the final decision should be made by MOs.

A patient is in severe pain, so s/he is pouring out all these complaints [on us], **but I can't contact the doctor...** and I'm in the middle of those two [the doctor and the patient, but I can't do much about it]... Otherwise, **[when the doctor] couldn't make decision** and say "Ah... we can't use this drug..." in patient's room... In a situation like this, **I come to think 'There is nothing I can do, even if I am restlessly jumping up and down.'** When I become restless 'There is nothing I can do, after I [try to] do [things that I can], I [talk to myself] **"Don't be restless. It's OK. I should be thinking relax."** There are times that I say [to myself] **"OK, that's enough [I had enough]."** When I face this kind of situation, I think I become like this... (Jina TM24).

Nurses appeared to experience professional conflict, as they undervalued what they do in managing pain for those patients with cancer. This seemed to be due to the medically-

focused work culture and content of the NTGB, which did not reflect nursing professional concepts and scope. This resulted in nurses' perceptions about their own practice as limited. The nurses could be disengaged from providing quality care, but were also frustrated in every day practice, when this pattern of experience continued.

Theme 3.2. Sense of powerlessness and frustration: Therapeutic intent vs patient outcomes

As described in a previous theme, Jina provided care for Daewon who had uncontrollable pain after chemotherapy. Despite Jina's desire to minimise the pain Daewon was experiencing, the impossibility of identifying the cause of pain within their knowledge base and inability to provide sufficient interventions led to negative patient outcomes; this seemed to cause feelings of powerlessness and frustration.

*... although I wasn't a doctor, I really wanted to give him something to sedate him, so we could do whatever we had to do without him feeling pain. But, he wasn't in any condition that he could tolerate any interventions... Well, there is **no way** [to help him] ... No verbal sedation! If I tried to encourage him to talk, it would cause him headache, he would have felt his brain was shaking... **Of course, no massage** [was possible], no way for that... That was just... really, really... **it was really too cruel**... I thought it was just **too cruel for him** [if I had to try any interventions on him]. There was **no other thing that I could think of** [to provide in order to reduce pain]. // **When I entered in his room**, I only could think... well really, **'how could a man ...?', 'how could...?' something like this.** // ... sometimes I entered his room to help dressing, because it couldn't be done by one nurse, then it [looking at him in pain] **broke my heart**... (Jina).*

Jina eventually expressed her feelings when she provided care for Daewon, as heartbreaking and leading to frustration, given her perceptions of the limitations of interventions that she could provide. She wanted to provide sufficient care without causing pain, but she did not know how to deal with the situation and Daewon's pain was not resolved; this caused her greater frustration. She seemed to be fighting between those feelings arising from this frustration that instigated thoughts of wanting to do anything for the patient even things outside her scope of practice; she was expressing sympathy towards the patient's suffering. Moreover, such stubborn pain could minimise

the nurses' willingness to use different options, concerned that it could worsen the pain, which could be harmful for Daewon. Jina seemed to consider her actions as a potential source of causing pain, even if she tried some non-pharmacological interventions, and thus she hesitated to use them.

Considering Jinhee's position in the ward where she was Acting Charge Nurse and her work experience as a nurse, she would be expected to express her opinions more. However, she still seemed to be very hesitant to directly talk to the MOs about concerns regarding overuse of pharmacological interventions.

I didn't feel like I should give it [opioid analgesic]... at least I should prolong the duration of giving the next dose [of opioid analgesic] a little bit, so I notified the doctor [with the intention], but the doctor said [give opioid analgesic as the patient requested], because the patient seemed alert when he saw him... but it was not them staying at the bedside for 24 hours, but we were closer to [the patients to] look after them. Although we told the doctors, [they didn't listen but] said "just give it as the patient asked"... until the incident... that [the patient] hurt his head [due to a fall]... The registrar didn't know what happened and [the patient] was crying when the professor was on the rounding [and the patient] said [reported to the medical consultant] that the nurses didn't give him [opioid analgesic]. [The professor asked why we, the nurses didn't give the patient opioid analgesic, although he asked for it... Initially [the professor ordered us] to give it every 3 hours on time... I mean, I was in the position that I have to give it out... so I felt a bit down... [I had to follow the doctor's order, but I don't fully agree] and the patient had the incident [fall] (Jinhee).

Despite nurses' therapeutic intent, inadequate communication between the nurses and the MO seemed to cause unwanted outcomes. It appeared that inadequate communication resulted from the combined sources of the hierarchy and working culture; the nurses felt uncomfortable in expressing their own concerns, and lacked the confidence to communicate with the MO about the proof of evidence given the lack of assessment. Thus, the nurses had to act on what they were told, although they could not agree on the decision; this caused feelings of powerlessness and frustration about their practice.

Theme 3.3. Anger and failure to embrace unique characteristics of patients

Nurses' expressions of anger could be due to their failure to embrace unique patient characteristics. For example, Jina reported a story of Boyeon, who she considered as a sensitive patient, because she did not show her trust of nurses including Jina herself. Jina expressed feelings of anger and irritation when she shared the story of Boyeon, a patient with breast cancer who also had multiple metastases. Jina described Boyeon as a patient who was quite sensitive, non-compliant and wanting to run her treatment her way from the time of admission.

*It was a breast cancer patient, and she was **in the terminal stage**. So, she **came to our ward for hospice care, but she already had multiple metastases and so she had severe whole body oedema**. She wasn't as bad when she first came in but as the disease progressed she became like that. But she was **personally sensitive from the beginning**, so she was like that even in the previous ward... she had a reputation of being a difficult patient ... I mean with her personality. Well, I mean, like treatment, how should I say? She wasn't the person who cooperated with [us] for her treatment, **she rather wanted everything to be progressed in her own measure**. So, one minute she said "I need to have fluid [IV fluid]. Put me on [a bag of] fluid. Order [a bag of] fluid for me." So, she got a bag... probably she started complaining again in 5 minutes like "Oh, stop this fluid. I feel my body is swollen up, because of this fluid." If we didn't stop it right away, she would go crazy. She would yell at people and go crazy ... (Jina A-III-3).*

Boyeon's behaviour that Jina considered as overly sensitive and non-compliant could be a reflection of her level of anxiety about the stage of her disease rather than intentionally being sensitive and giving healthcare professionals a hard time. Jina described how Boyeon responded after she had an injection, a placebo, in order to illustrate how sensitive Boyeon was.

*We **had to use placebo at one stage, which caused her pain to subside, but later she said 'This upsets my stomach. I think this is too strong for me.'**, although it was only a placebo (Jina A-III-3).*

It would be difficult to identify if Boyeon's behavioural issue was due to her character or because her anxiety exacerbated her behaviour, unless Jina attended a comprehensive appraisal including psychological assessment. However, Jina, after a brief period of time, seemed to come to a conclusion that Boyeon was extremely sensitive without thorough assessment or consideration of other possible causes in the situation. She then

considered Boyeon as a troublesome patient. Therefore, they decided to stop the fluid, as Boyeon had requested, in an effort to stop her making complaints. Such responses could indicate that there was no principle informing care including PCC, or an evidence-based care plan with some goals; it simply showed the nursing practice was reactive in an effort to resolve visible tasks.

Jina's practice manner that failed to consider all options for particular behaviour could limit the extent to which she could empower patients around their own approach to care.

Because the situations turned out like this, I came to think that it was all because of her [bad] character [that she was so capricious]. I've become little bit... like... 'Yeh, you do whatever you wanna do.' Later I almost become "I'll do whatever you want me to do." // I feel a bit empty, bit angry, ... got angry and irritated ... it will be good, if she trusts the healthcare professionals and does things how they are instructed...' but she doesn't listen to us but requests things a lot... I get really angry and irritated when I see something like this. I also think something like 'Why has she come to the hospital?' and I get angry. I know I shouldn't dislike her just like that, because she came in with sickness, but because I'm also a human being..., I [become] have antipathy. I kind of don't want to go to see her, because I know once I go in [to her room], I can't get out [of her room because she would keep asking one after the other and changing her mind]. I become angry, because I start thinking I won't be able to get out, when I'm busy (Jina).

A lack of a trust relationship between a healthcare professional and a patient, limited understanding about the whole patient through comprehensive assessment, and a failure to embrace unique characteristics of patients seemed to be causing the nurse negative feelings, including anger and irritation. Also, because Jina could not handle her own negative feelings, it prevented effective communication with the patient, and thus had the potential to disrupt chances of maintaining a therapeutic relationship. She was tempted to give up on providing adequate care, but just act on diminishing the number of current complaints rather than solving the actual issues; that might waste her time even more. Jina appeared to blame Boyeon for being a non-compliant heavy complaint maker and wasting her time. She seemed to have ethical responsibilities that she needed to face within this situation and should have interacted with the patient in a professional manner. However, she also had a conflict within her own mind due to feelings of dislike of the patient, given an atmosphere of blaming. This might suggest that Jina's

professionalism as a nurse could be failing and there was no concept of a PCC approach. Failure to understand and embrace the difference of each individual patient seemed to cause a vicious cycle of poor nursing care and patient outcomes.

Theme 3.4. Incongruence reflected in the professional mirror

Healthcare professionals including nurses often seemed to be unable to see a level of incongruence between what they chose as a nursing action and the actual needs that patients expressed. Incongruence between the care that Daewon received and what he needed was illustrated in Daewon's case outlined previously.

*Now, **doctors from PS [Plastic Surgery] and [staff from] our ward jump into him to do dressing [to prevent infection]...** Now, that patient with skin [problem]... **I even can't touch him.** I can't hold his hands, because it causes pain even with slight touch... For him, even when he moves his bowel, it is hard to clean him up. His skin was just like the one with burn... really... **although we infused Morphine [mixed fluid] continuously, it couldn't stop [the pain]** (Jina).*

An approach for the pain management for Daewon was limited to Morphine infusion. Even after they could see the potential cause of the pain, the peeling skin, they might consider the pain as an unavoidable part of the treatment process. It was evident that the healthcare professionals were more focused on infection prevention by attending to dressings based on the answers from the consultation; but did not attempt to use other interventions for managing pain beside the continuous infusion of Morphine. Jina's description regarding how they attended Daewon's dressing showed there was not much attention to the pain, which was a significant issue for Daewon at the time. They provided changes of dressing as a way of preventing extensive infection seeing this would be the healthcare professionals' major concern and priority. However, no extra pre-intervention for pain aside from his regular Morphine infusion was described, although agonising pain was predicted during the dressing changes. Jina later stated that there must be some topical application in the PS outpatient unit that they could have used in this case, but she was not sure about it and in fact, no such pharmacological intervention was used for

the patient even after the referral to the unit. This could indicate a lack of knowledge about the resources they had and limited usage of what they knew was available. In addition, the patient could have been referred to palliative specialist since pain management is one of their major areas of practice. It also could represent the situation of the study setting in that there was a lack of standardised models and/or absence of role models in providing adequate care, rather than that the healthcare professionals, including nurses, were entrapped in their professional mirror without seeing the patients' true needs.

Eunah recalled an experience of caring for a breast cancer patient, Sunok who was requesting

*... analgesic ... there was a case that **[the patient] knew about opioid analgesics and depended on it. Although she was already on Morphine mixed fluid through iVac [Intravenous infusion pump], she kept saying she was in pain and asked to increase the dose. If we decreased the dose even a bit, she couldn't bear her pain.** So, we even had to **give her a dose of placebo with saying it was opioid**, because she complained that the drug didn't seem to be infused. ... Yes, it [placebo] worked. It was **clear that the placebo was effective**. So, I thought there could be a **significant difference between when we said [verbally expressed that] we were giving opioid and when we didn't mention it [giving opioid]**. // I think she was a breast cancer patient. Yes, she was **in the terminal stage with whole body meta [metastases]**, so **there was nothing that we really could do**. At that time, she hadn't had any treatment, like Chemo [Chemotherapy] or Op [operation] at all [although she had a cancer], so when she came back to us later, there was nothing we could do except pain control. Because she was on DNR, we used plenty of medications, compared to other patients. However, she was really anxious and in a lot of pain, that was the case [that I remember] (Eunah).*

Eunah seemed to have preconceived ideas about Sunok that she was counting on the opioid analgesic. However, considering the fact that she had not had sufficient treatment when she was first diagnosed with cancer and was not in a stage for active treatment of cancer, she could be in severe pain as well as frequent breakthrough pain. Also, as she described Sunok as being really anxious, that anxiety could increase the level of pain that Sunok experienced. If this was the case, there should be consideration that the provided pharmacological intervention might not be adequate to manage her pain,

although the care team considered that they gave enough pharmacological interventions. The effectiveness of the placebo that Eunah stated Sunok experienced might not be from the placebo itself, but from Eunah's explanation confirming it was the requested opioid analgesic; this might have provided psychological comfort to reduce anxiety.

Given there was a public campaign to prevent inappropriate drug use in South Korean society, it might not be uncommon for nurses including Miho to have negative perceptions towards the use of opioid analgesics. Despite Kisoo being in a terminal stage and frequently complaining of pain, Miho expressed her concern about Kisoo having PRN Morphine too often. She came to a conclusion that it was because Kisoo was dependent on Morphine, before she obtained a comprehensive assessment with the perception of Kisoo's pain experience as being a multidimensional phenomenon.

It was a male patient [Kisoo] who had AGC [Advanced Gastric Cancer] with obstruction, so he even had an ileostomy operation and he was at a really terminal stage. Also, he had a blockage in the Kidney, so he had PCN [Percutaneous Nephrolithotomy] as well. So, he absolutely [was in pain]... Now [he] has 3 tubes. Anyway, he's having 200mg of Morphine continuously per day. Having 200mg... [Although he's] continuously having a total of 200mg [Morphine] per day, [he] says he's got ongoing pain, so he sometimes has 15mg of [Morphine] Sulphate. Although the part [the treating team for him] said to give it twice a day, he actually had it maximum 6 times a day [we had to call the team for more orders and then gave him 6 times a day], if he said he was in pain. I mean, if you see the time [frequency], it's for 3 to 4 hours... It doesn't last for more than 4 hours, after he had the [Morphine Sulphate] injection. I mean it could be OK, but he has [Morphine] too often. The patient initially kept saying "I'm in pain... pain... pain", but now because he knows he only can have the injection every so often, he comes out right on time. Or otherwise, when we go into the room, he would say "It's time for my injection. Give me that injection." He talks like this. If [we increase the dose more than 15mg per injection,] he has dizziness, vomiting and nausea. Because he was quite sensitive to respond to that [increasing the dose] ... It was the maximum dose [that he could have for extra dose] (Miho).

Miho also shared her experience of caring for another patient with cancer and pain.

When I was working a few days ago, he [Doosik] kept coming out to say he was in pain, although we've done everything that we could've done. And here... he was receiving [continuous] Morphine injection. We gave him about 50cc? 30cc? [of Morphine mixed fluid] as a rapid drip to manage his pain. But I don't think he considered those drips as an intervention [for his breakthrough pain]. Even though, [analgesic mixed fluid] is continuously given, [he kept saying] he was in pain. So, even I said to him that we've administered

more [through rapid infusion], but he was still saying “I’m still in pain. I’m in pain.” So, I talked to the on-call doctor, but the doctor said no more could be administered [at that point], because he had as much as he could have [including injection] and all his oral medications, and we did that [rapid infusion of analgesic mixed fluid]... In fact, the patient experienced a slight mental change a few days ago. Because of that, the doctor couldn’t [didn’t want to] give [more] carelessly ... (Miho).

It appeared that the healthcare professionals including nurses did not take patients’ self-report of pain as needing further investigation or changes to interventions; but they rather claimed that they had provided all they could after giving a bolus dose of the analgesic mixed infusion as a rapid drip. Doosik might not achieve the goal of pain relief, because the current intervention was not enough to reduce his pain. This only could be known through attending to a thorough assessment and through use of different interventions. However, their perception of interventions seemed to be limited to a few pharmacological options, which demonstrated the entrapment of their own professional mirror.

Conclusion

The findings presented in this chapter illustrated the limited extent to which nurses were informed about, or embraced, the national guidelines for pain management. Despite the use of their own NTGB, this was clearly inadequate in terms of providing directions for nurses reliant on a full suite of roles and functions around pain management.

While the CPMG provided direction for MOs, especially around pharmacological interventions, they provided limited directions for nurses, especially around the use of different interventions. This led to a sense of powerlessness and frustration for the nurse participants. Nurses’ usual practice was ‘transactional’ and not always reflecting careful consideration of the patient experience. Anger and a sense of failure to embrace unique characteristics of patients arose because often nurses were not clear about the appropriate nursing response to patients’ needs.

The storylines from ten nurses describing their experiences of caring for patients with pain related to cancer elaborated upon their sense of anger and frustration around their failure to embrace the unique characteristics of patients. They acknowledged the undervaluing of nursing actions, and their sense of powerlessness about the less than optimal patient outcomes. When they looked into a professional mirror, they could see the incongruence between their actions and the patients' needs.

Contemporary nursing demands an EBP to pose solutions through judgements arising from clinical decision-making processes. It seems reasonable and rational that nurses' roles and functions be seen as critical to the achievement of optimal patient care involving pain management. The findings in this chapter presented under three superordinate themes, i) *Innovation: is it there?* ii) *Nurses' usual practice for managing cancer pain* and iii) *Nurses' experiences of managing cancer pain* show a high level of dissonance between the intent of the guidelines and the uptake of relevant elements by nurses. In Chapter Five, not only the issues relating to the pre-assimilated stage of the CPMG as a representation of using EBGs, but also the issues relating to the usual practice of nurses for managing cancer pain, are discussed in depth and breadth.

CHAPTER FIVE

DISCUSSION and CONCLUSION

*Evidence Based Practice (EBP) is “a **problem solving approach to clinical decision making** that incorporates a **search for the best and latest evidence, clinical expertise and assessment, and patient preference values within a context of caring**” (International Council of Nurses [ICN], 2012, p.6).*

Introduction

Providing nursing care for those patients with cancer in managing pain based on evidence has become critical, because EBP can improve the quality of care and patient outcomes (Choi et al., 2014). As pain is an individual patient experience, nurses who provide care for those patients with cancer are required to develop their ability to make clinical decisions for those individuals using the best evidence that reflects the particular patient's situation (Eaton et al., 2015). Implementation of the use of EBGs in nursing practice in managing cancer pain is an effective way of achieving EBP and optimising the patient outcomes (Brink-Huis et al., 2008).

This study used critical ethnography to investigate the impact of the introduction of the CPMG on nursing practice in cancer pain management in a South Korean healthcare context. Given that the nursing practice is situated within the historical, cultural, economic and political context, it was important for the researcher to employ the critical paradigm which allowed her to fully understand all the aspects of their practice in their social world.

The researcher recognised that the implementation of CPMG in nursing practice would occur within a context that incorporated the existing relationships between patients, families, doctors and nurses within the organisation in which care processes were situated. This meant that the impact of the introduction of the CPMG would be envisaged, constructed and maintained through the actions of all involved. The existing ideologies within South Korea such as Confucianism, collectivism, capitalism, and classism would

also potentially influence choices and decisions about care (Gilbar & Miola, 2015; Sleziak, 2014). The researcher immersed herself into this context using critical theory to analyse the impact of the introduction of the CPMG on nursing practice, and taking account of the socio-political, cultural, historical and economic contexts.

The research question, 'What is the impact of the introduction of the Cancer Pain Management Guideline on nursing practice in South Korea healthcare context?' was asked with some sub-questions including;

- a. How do nurses provide care for the cancer patients who are experiencing pain in one acute healthcare setting in South Korea?
- b. What do nurses do in their practice of pain management?
- c. What policies, procedures and guidelines are used in cancer pain practice?
- d. What are the experiences of nurses in relation to cancer pain management?
- e. Is practice consistent (or inconsistent) with evidence-based international guidelines for cancer pain management? In what ways is this so?
- f. What are the facilitators and barriers to the uptake of the CPMG in Korea?
- g. What are the barriers to cancer pain management and the use of the evidence-based guidelines?
- h. What are the facilitators to cancer pain management and use of the evidence-based guidelines?

The following discussion of the findings of this study were informed the writings of LoBiondo-Wood and Haber (2010) who invited researchers to consider the following elements.

1. Why did the nurses not know about the CPMG? Why did the nurses practise pain management in the way that they reported? Why did the nurses report on their experiences on pain management practices with various patients with cancer in the way that they did? What are the ingrained elements of knowledge, behaviour

and shared understandings and assumptions about cancer pain and its management in this particular setting and context?

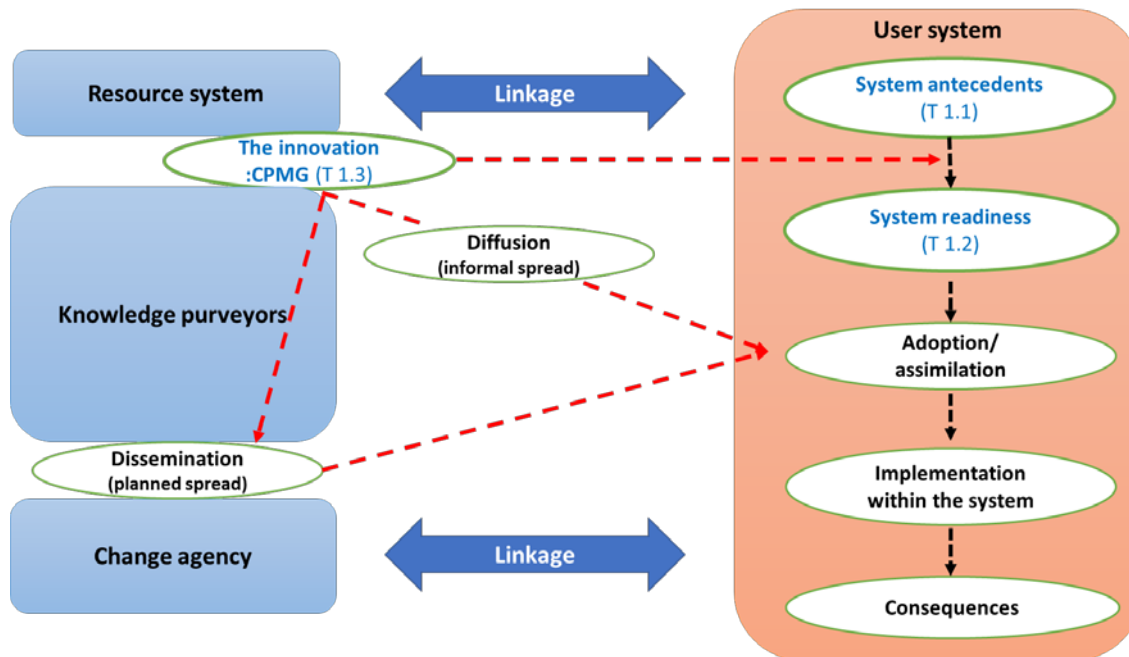
2. Do these elements matter? What is their significance to change in education and practice?
3. Whose interests are being served or not being served by the potential implications of the findings? Who is gaining and/or losing from the situations described?
4. Whose voices are being excluded from policy development and implementation? And why is this so?
5. What actions and changes need to be facilitated as a result of the findings and by whom, e.g. How could it be otherwise within the nursing profession?

What follows is in-depth discussion on the issues that emerged from the findings presented in Chapter Four. The researcher illustrates figures that have emerged from the findings, which also answered the research questions and revealed critical issues around evidence-based cancer pain management. These issues include; 1) the medically driven nature of the development processes for a set of guidelines suitable for use as EBGs; 2) an absence of evidence of the organisation's role in support of EBGs and subsequent support for quality care and work culture making; 3) the value of the nursing contribution, and an apparent undermining of the nurses' role by all involved that subsequently caused inadequate management of cancer pain; and 4) lack of patient-family centred care aligned with therapeutic partnership and mutual respect. Appraisal of these issues will be critical to facilitate any suggested actions and changes from within the nursing profession as a result of this study.

The discussion of each issue will be presented after a brief summary of the relevant findings with figures, and the implications and recommendations are also discussed

before it will be recaptured in the final statement of this thesis with the final model of recommendations depicted in Figure 5.3.

Figure 5.1 *The Implementation of the CPMG (Modified from Greenhalgh et al., 2008)*



5.1. Issues related to Guidelines and Organisation

There was a need to consider whether or not the setting appeared ready for using the CPMG as a major source of evidence to support practice, or whether any evidence of recent innovations in nursing practice around pain management for cancer patients existed. The researcher's journal reflections on i) the observations of nurses' practice including their interactions, activities and dialogue, and on ii) the structural and organisational features of each unit, has led to the considerations about the elements in the conceptual model of Greenhalgh et al. (2008), the diffusion of innovation in organisations.

The ideas about diffusion of innovation provided by Greenhalgh et al. (2008) were used to constructively interpret and reflect on the emergent themes within the data in relation

to the research questions. This included the elements of 1) the innovation (CPMG), 2) resource system (*within the hospital*), 3) knowledge purveyors (*nurse managers and educators*), 4) potential change agents (*any nurse who knew of the existence of the CPMG*) and 5) user systems (the 3 Units, where nurses who participated in the study worked). Among those elements, only the innovation and some elements of the user system such as system antecedents and system readiness, were reported on by the participants and observed by the researcher for this study (See Figure 5.1). Some emergent themes reflected findings consistent with those three elements, the innovation, system antecedents and system readiness. Therefore, within Figure 5.1 those three elements are presented in blue, but the broken arrows indicate the absence of flow of changes as the CPMG was not used in this study setting as an EBG to guide their clinical decision making in managing cancer pain.

One of the system antecedents for innovation was absorptive capacity for new knowledge. This should be demonstrated, if it exists, in a work culture that uses guidelines in nursing practice in terms of sharing knowledge and skills. As seen in Chapter Four, there was no evidence of the use of the CPMG among nurses, but the nurses were guided by their own NTGB for pain management, when they provided care for those patients with cancer. This could affirm pre-existing knowledge and skills or suggest absorption of new knowledge around the innovation; the latter shows there has been recognition for the need for using guidelines to optimise the quality of care and patient outcomes. In this study, regardless of its value as an EBG, the application of nurses' knowledge and skills had been based on the NTGB rather than the CPMG.

Receptiveness for change among nurses and the organisation is another important system antecedent, as adopting an innovation like the CPMG would require every individual nurse to make some changes in their practice. This degree of change demands a work climate that is receptive to challenges but supportive through any change process.

The findings indicated that potential barriers such as the atmosphere of the organisation did not support the initiation of new ideas and practices, and led to limited support in resources, both human and material.

Although there were some reports of positive changes in cancer pain management among MOs influenced by practice changes among the medical leadership, tension for changes in managing pain among nurses was externally mediated by their participation in and achievement of accreditation in the study setting.

Therefore, the analysis of the above findings has revealed two major issues; the medically driven nature of the development processes of a set of guidelines suitable for use as EBGs; and an absence of evidence of the organisation's role in support of EBGs and subsequent support for quality care and workplace culture making. These issues will be critically discussed as follow.

5.1.1.The medically driven guidelines as EBGs

This study led the researcher to look into the world of nurses in a Korean healthcare system by examining their nursing practices when managing pain and to determine the use or non-use of the CPMG for patients with cancer. Use of an evidence-based approach such as the implementation of EBGs in nursing practice is critical as it optimises patient outcomes, improves healthcare practice including nursing care, and ensures accountability of healthcare professionals as outlined by the ICN (2012). The use of EBGs is believed to enhance the safety and effectiveness of care for individual patients, which in turn allows professionals to respond to the best interests of each individual patient in managing certain issues such as pain (Mackey & Bassendowski, 2017).

A well-developed set of EBGs for managing cancer pain follows a systematic development process (Brouwers, Kho, Browman, Burgers, Cluzeau, Feder, Fervers, Graham, Grimshaw, et al., 2010). Evidence based recommendations (Green et al., 2010) are considered an innovation among healthcare professionals including nurses, as these guide the uptake of new evidence into practice. This study was premised on the assumption that the introduction of national guidelines in South Korea was an ‘innovation’ at the time and their application to practice should have become a feature of usual practice in some settings. A movement intended to spread the use of the CPMG among healthcare professional groups including nurses was apparent when initiatives like the CPMG were presented at conferences. Reports about updating approaches to care in network systems had been observed in the Korean healthcare systems since the introduction of the CPMG in 2004 and are to be commended.

However, as shown in the previous chapter, the uptake of the CPMG was incomplete because the adoption of the innovation was not evident in the practice of the nurses in this study setting, despite the development of the CPMG and encouragement for its use by healthcare professionals, especially nurses.

The findings suggested that although the nurses’ practice was not impacted by the CPMG, nurses’ pain management responses were governed by directions within the NTGB. The NTGB guided nurses’ pain management for those patients with cancer by referencing assessing, intervening and evaluating pain. Also, it provided a framework to set up the ‘Pain Record’ in the EMR system. The situation observed in the study setting led the researcher to ask the following questions: Would it matter that the nurses were guided by NTGB instead of CPMG? Why would it matter? Could the NTGB be the EBGs for cancer pain management for nurses?

It matters because the CPMG required improvement in care through use of a high quality EBG, while the NTGB was very limited in content and it was unclear how it was developed. Hence, it had limitations in guiding nurses' clinical decision-making. In various situations it contributed to nurses completing tasks in a transactional manner. This was reflected in a level of dissonance and incongruence between what nurses thought about their scope of practice (range, breadth and depth) around pain management and the need for alternative responses to patient care dictated by the CPMG. The essential elements of the CPMG that also mattered for nursing care for patients were missing. This was important, given the medically orientated environment of both the development and implementation of the guidelines. More fundamentally, it matters because there is doubt emerging from the findings about whether the pain management by those nurses was based on the best available evidence for care that would meet the patients' needs in the best way possible.

The nurses who practised under direction from the NTGB reported that they often did not give primacy to the patient with pain and that the interventions directed were not evidence-based. However, neither the NTGB nor the CPMG provided complete directions for nurses consistent with EBP, despite the significant changes that the development of the CPMG brought in Korean healthcare practice including greater use of a variety of opioid analgesics (Heo, 2007). It was clear that the patients did not receive optimal pain management, nor were the nurses satisfied with the care that they delivered as illustrated through the participant nurses' sharing of storylines about their experiences. For example, the nurses including Kyoungmi and Jina described the patients who were suffering, because their pain was not managed well. This in return caused feelings of frustration and powerlessness that even led them to become disengaged in providing optimum care. Given this, it was essential to explore why nurses did not know about the CPMG and what alternative sets of knowledge, beliefs and assumptions were engrained historically, culturally and socially, dominating the nurses' practice.

First, the guidelines only can be meaningful and beneficial for the nurses, when they have relevance (Brouwers, Kho, Browman, Burgers, Cluzeau, Feder, Fervers, Graham, Grimshaw, et al., 2010). The analysis of the data from the interviews, observations of actual nursing practices in three units and document review showed that the nurse's advanced role in professional activities that place patients at the centre of cancer pain management strategies was not acknowledged and incorporated. It is not surprising that the end product seemed less relevant to nurses given the guidelines are medically focused. The major contributors from within the healthcare professional population, involved in developing the CPMG were MOs. The 25 groups involved in developing the CPMG were listed at the back of the guidelines and included two nursing academic associations/societies and a multidisciplinary academic society. The original guidelines were not developed and presented in a manner that demonstrated inclusion of a range of stakeholder perspectives including those of nurses. Along with social expectation of a hierarchical relationship between medical and nursing that has a long historical sphere of influence, only a limited level of nurse participation was expected. At the outset this expectation minimised the nursing voice in the development process. This set of expectations flowed through to the workplace and patient care.

While the CPMG cited a range of healthcare professionals as the intended users, it subsequently appeared to limit the intended users to the MOs through the explanations of the processes for managing pain. For example, as shown in the Chapter Two, the statement specified 'Doctors need to educate patients/family to use the pain scale even at home in order to achieve effective pain management at home' in the beginning part of pain assessment. This was in direct contrast to the statement in the introduction that indicated the intended target as all healthcare professionals. The guidelines also highlighted important elements that were recommended as a part of cancer pain management strategies, but most of the recommended interventions needed MOs'

involvement in making decision on the use of the interventions and limited the nurses' independent use. Even the interventions that were identified as non-pharmacological were not necessarily those that did not need the use of drug, but were more likely to be procedures such as various radiation therapies and nerve blocks that needed MOs for completion of the main roles. This cannot be appropriate for the nurses' sole and independent use as their scope of practice does not extend to the prescription of necessary drugs for the procedures and/or even performing such procedures. It could have involved nurses but there was only a brief presentation of the list of different complementary/alternative therapies that could enhance the pain management outcomes without detailed description about each of the suggested complementary/alternative therapy approaches. This is likely to have limited other healthcare professionals in referring to or using these when engaged in cancer pain management practices and it could have reinforced the tendency for the CPMG to be used by MOs and for cancer pain management to be seen as medically driven. Although, it is common to adapt the guidelines for use by other healthcare professional groups such as nurses (WHO, 2012), the manner in which the CPMG was developed and presented may not be attractive or meaningful enough as incentives for adaptation among nurses.

Given that the CPMG was not designed to be inclusive of the contribution of nurses in pain management, but were clearly medically focused, there were therefore no incentives for nurses to reflect on their practices around pain management. This outcome warrants further consideration of the importance of the involvement of more nurse clinicians and academic groups in developing and updating the CPMG, as their voices would have been heard at the outset. Along with the contextualisation of the guidelines, there should be consideration that the guidelines be more practical, easy to conceptualise, simple and easy-to follow, as nurses would want to use such guidelines during their busy working hours (Jun, Kovner, & Stimpfel, 2016). It may not be a major

concern whether the guidelines are new or updated from the existing guidelines, but that they include consideration of such aspects that have been discussed above.

5.1.2.The organisation: Supporting nurses by providing sufficient resources and improving workplace culture

There have been a lot of changes in Korean healthcare systems such as achievement of formal accreditation (Kim, 2012a) with the claim of establishing customer-centred environments that provide more choice of care, and its evaluation by patients (Kim, 2016). The primary purpose of achieving accreditation would have been to demonstrate improvement of care quality by using EBGs. Indeed, Yoon (2015) reported in her study that the nurse acknowledged the improvement in care quality and the support of resources that led to the achievement of accreditation.

In this study setting, achieving international accreditation appeared to be essential, given the recognition of the need for proof of the quality processes and outcomes within the healthcare system. Despite the organisation's achievement of accreditation and the development and use of their own NTGB as indicative of attempts at improvements, the accreditation process itself was considered by nurses as less relevant to them but rather a means of promoting the reputation of the hospital to the public. Accreditation could have been a crucial opportunity to introduce and implement the CPMG as EBGs and to improve care quality, however there are several issues that need to be further explored in order to understand why nurses in this setting did not see that the accreditation achieved improvement in care quality inclusive of nursing practice.

First, there has been no shared understanding about the achievement of accreditation and the use of EBGs as the way of improving care quality in caring for patients with cancer who are experiencing pain. There was no evidence of formal introduction of EBGs

as essential components of accreditation to nurses at organisational level, but the nurses kept using the guidelines that had the potential to limit their practice in managing cancer pain. This resulted in a suboptimal level of nursing practice and inadequate management of cancer pain among patients, despite the achievement of accreditation. This clearly indicates that the purpose of the changes was not clearly set up by the organisation and/or communicated to the nurses as improvement of care quality and patient outcomes. As highlighted by Park (2013b) and Yoon (2015), nurses' understanding of accreditation and its implementation has a strong positive influence on nursing practice in terms of reliability of their roles with providing care including pain management and maintaining therapeutic relationships with those patients with cancer. El-Jardali, Jamal, Dimassi, Ammar, and Tchaghchaghian (2008) also report on implementation and indicate any consequent changes that have not been initiated by nurses themselves may not bring meaningful changes in their nursing practice including cancer pain management. **Their willingness to continue and make the changes at an advanced level may not be guaranteed.** However, the nurses in this study setting reported their limited understanding about the purpose of achieving accreditation. They also expressed their frustration and pessimism about the changes that they had to go through during the preparation of and involvement in auditing for accreditation. This all indicates that accreditation processes, if well prepared for by the organisation, could have provided the crucial opportunity to improve care quality and nursing practice including cancer pain management, but unfortunately this chance was missed.

Second, the nurses in this study reported that there was no sufficient initial and ongoing support for resources to undertake additional tasks imposed on them due to accreditation processes. Clearly, achieving the accreditation caused tension through initiating some changes directly impacting on nursing practice including pain management for those patients with cancer; assessing/reassessing pain and relevant documentation is an essential element of determining the quality of care in the accreditation process. As

described in the findings chapter, completion of the electronic 'Pain Record' was strictly adhered to and nurses were highly compliant in the study setting. However, the quality of the documentation did not meet the level it should meet as a fundamental communication tool. The nurses in this study clearly reported that accreditation processes demand ongoing efforts on not only healthcare settings, but also individual healthcare professionals in preparing for and maintaining the status of achievement. In particular, the nurses' experiences have worsened, given a lack of time spent with patients, an essential part of quality care, because of the excessive task and overload of activities involved in preparing for an accreditation event (Kim, 2012a). In addition, it was reported that heavy requirements of obtaining documentation for the accreditation process were one of the challenges among nurses, in this and other studies (Kim, 2012a; Kim, 2012b). This is consistent with previous studies. Devkaran and O'Farrell (2015) reported the use of excessive and various measurements such as patient assessment, initial medical assessment, initial nursing assessment, pain assessment and pain reassessment which was one of the significant negative changes and effects of accreditation on quality performance outcomes. They further highlighted their observation of performance plateaux once the surveyors have left the hospital on completion of the accreditation.

Despite reports of several advantages of achieving accreditation including improvements in care processes and use of information (El-Jardali et al., 2008; Yoon, 2015), the negative influences of accreditation prevailed. Insufficient support to accomplish the required tasks was apparent, along with a lack of understanding about the purpose of the accreditation, when the negative influences of accreditation prevailed. The changes may not have been sustained after the achievement of the accreditation, despite the initiation of changes at the organisational level. This has implications that any changes including the implementation of accreditation and use of EBGs for promoting care quality

and patient outcomes warrant organisational commitment to adequate initial and ongoing resource support.

Another area that revealed insufficient support from the organisation was apparent in the reports of shortages of human resources. Perceptions of excessive workload due to insufficient staffing is one of the most frequently and extensively reported barriers in all areas of nursing including in this study setting. It is reported that South Korea is one of the countries where the number of nurses per population has significantly improved, showing incremental improvement when compared with all OECD countries (OECD, 2015). However, it is still one of the countries where the nurse to patient ratio is high. Increasing the number of nurses per capita is the result of governmental endeavours allowing the establishment of more nursing schools and/or increment of newly enrolled nursing students in order to solve the issue of nursing shortage (Lee, 2017; Lee, Kang, Ko, Cho, & Kim, 2014; Park, 2012a). However, there are several reasons, including expansion in the size of hospitals and the increasing number of inpatient beds without recruitment, that impact on the necessary quality indicators and thus the need for appropriate increases in the quantity of nurses. Poor retention rates for nurses means high nurse to patient ratios continue (Park, Seo, & Lee, 2013). Lee et al. (2014) pointed out that only 4.7 nurses per 1000 head of population are working as nurses in Korean healthcare systems, whilst the average of 9.1 nurses are on duty among the OECD countries. The ICN (2015) reported that one Korean nurse appeared to have average of 18 to 20 inpatients within their responsibility for care on each shift, despite the recent government recommendation for the nurse to patient ratio of 1:13. This report is consistent with the participants' report of how many patients they look after each shift in this study setting as unreasonably high at 1:18.

The impact of nurses' experience of excessive workload with the regular and additional tasks required on each shift in this study setting is reflected on nurses' struggles with

routine care delivery such as pain management. Williams, Perillo, and Brown (2015) in the scoping review of organisational factors around EBP emphasise nurses' reports of inability to engage in EBP, given the lack of time with increasing demands of patients that cause nurses to prioritise routine tasks such as administering medication. Similarly Jun et al. (2016) emphasise that excessive workload causes nurses to be hindered in the use of recommended guidelines regardless of their recognition of their advantage in patient outcomes, because they struggle with completing routine tasks. Cho's (2015) examination of the effects of nursing staffing on patient mortality, revealed that almost 70 percent of the nurses considered their quality of care as fair or poor as their workload is excessive.

There is clear evidence that sufficient staffing of nurses can give nurses more opportunity to spend most of their time with patients (Kane, Shamliyan, Mueller, Duval, & Wilt, 2007). This is fundamental to providing direct care as it ensures greater chances for establishing therapeutic relationships, and promoting patient safety and care quality (Cho et al., 2016). Obtaining adequate levels (in quality and quantity) of nurse staffing can reduce possible issues with nurses' functions of monitoring and early detection of problems such as pain and pain related issues (Brooten & Youngblut, 2006). The excessive workload may not be an issue that can be solved with a simple strategy, but it should be considered as one important element in a range of inevitable contributors to limited care outcomes in cancer pain management.

Given this study did not focus specifically on nurse staffing, it only has limited data that can explain why the organisation does not support a sufficient level of nurses in terms of staffing, despite the strong evidence of benefits in patient outcomes that sufficient levels within nursing can bring. However, this issue cannot be exempted from this discussion. One critical factor to note is the inadequate reimbursement structure for nursing services under the current NHI system. This inability to access payment for some nursing services

could be a major barrier for the organisation in recruiting more nurses, and hence has led to high nurse to patient ratios. Most fees for nursing service are already included in the cost of hospitalisation under the current NHI in Korea, unlike the fee for the medical services that is paid as fee-for-individual services (WHO and MHW, 2012). Whilst the nursing services are not remunerated sufficiently, nursing workforce (26.3 percent of RNs and 26 percent of ANs) is more than half of the whole healthcare professional population in Korean acute healthcare settings, and thus it is often considered as a major component of expenses within hospital budgets (Park et al., 2013). It is the nursing workforce, that could be the first element subjected to negative adjustment when the organisations have to make financial cuts (Ko & Kim, 2008). Likewise, the hospitals are in increasing competition with each other and restructuring to reduce the expenses for nursing workforces worldwide; the Korean healthcare settings appeared to be not much different (Kim, June, & Cho, 2005; WHO & MHW, 2012). The implication of the issues discussed above is clear in that organisations should continuously find ways to improve alignment of staffing to patient needs resulting from attention to adequate recruiting and retention (Williams et al., 2015). Although persuading the current NHI system to change in order to receive fair reimbursement may not be easy, the organisation needs to support the nursing group by acknowledging the issue, while they themselves take strategic actions to deal with the issue in the whole healthcare system. Otherwise, ongoing excessive workload issues and related outcomes will continue and result in burnout and disengagement among nurses (Park et al., 2013).

Third, limited or absence of ongoing education/training was obvious around the issues involved with pain management. While ongoing education/training was available, and was seen as an essential prerequisite in providing quality care for patients with cancer, the nature of the sessions was not focussed on the nurses' roles and functions in managing pain.

Misconceptions about and inadequate responses towards cancer pain and its management were reported and observed as common/usual practices through the majority of participants in this study. Although education is not the only cause of lack of awareness of appropriate care, it is one possible explanation which is supported by abundant research (Alqahtani & Jones, 2015; Lai et al., 2003; Yildirim et al., 2008). The nurse participants in this study had limited chances of increasing their awareness of pain related issues through regular ongoing education once they started working in the study settings. Although, some nurses had pain management related education as undergraduate students, it was often discontinued as their practice experience expanded; this increased the chance of losing the value and relevance of that acquired knowledge and those skills that they had developed as nursing students. This has implications for the organisation in that there should be provision of professional development opportunities through ongoing, regular education/training. There is a particular role for nurse leaders and managers within the organisation to advocate for resources to meet nurses' learning needs and to construct programs of meaningful learning opportunities. As Meehan (2003) recommended, it should be the responsibility of the organisation and nurse leaders to provide regular ongoing quality education/training for those nurses to obtain/enhance their knowledge and skills as current and evidence-based to relieve pain and suffering for those patients with cancer.

Finally, it was evident that a negative workplace culture heavily underpinned the nature of relationships among healthcare professionals. Along with a hierarchical relationship between nurses and MOs, hierarchical relationships among the nurses (new graduate nurses-senior nurses-nurse managers) were also revealed in this study. The nurses' experience in a hierarchical workplace culture was reported as one factor that prevented achievement of optimum nursing practice. It limited therapeutic communication that could lead to exchange of ideas to improve patient outcomes. Becoming a part of the nursing team and functioning as one is a critical element to working as a nurse in a busy

acute healthcare setting, as nurses have to rely on each other to provide continuous care in managing pain for those patients in their care. However, as described in the findings chapter, an embedded hierarchy as part of the culture led to discomfort within relationships or even bullying in some situations. For example, as reported, in a practical way, senior nurses often take on roles of preceptors to provide educational support for those new graduate nurses. This relationship between a preceptor and preceptee can be based on an unbalanced power relationship over time, during and after the preceptorship, where bullying can occur (Chang & Cho, 2016). More than 50 percent of the aggressors in the workplace were identified as nurses including senior nurses and nurse colleagues (Vessey, DeMarco, Gaffney, & Budin, 2009). This was also well illustrated in this study in reports of the way in which the senior nurse and her colleagues responded to new graduates who did not meet expectations during preceptorship. Although the approach was described as being for training purposes, it was obvious that the new graduate nurse was not exposed to ways to effectively communicate. The manner in which the experienced nurses dealt with the situation could be considered as verbal abuse and/or violence as those nurses were in senior positions with expertise and an expectation of better knowledge/skills. This pattern of behaviour could perpetuate power imbalances (Formosa, 2015; Granstra, 2015). Although, it was evident that such a negative work culture existed and negatively influenced nursing practice and management of cancer pain, there was an absence of positive remedial action at the organisation level.

Although hierarchical relationships are believed to ensure harmony and strong bonds among nurses (Kim, Han, & Kim, 2004), negative workplace behaviours that have been created in such relationships can cause physical, psychosocial and/or emotional harm to nurses. It is evident in the literature that this causes burnout, disengagement and intention to leave, which in turn can negatively impact on quality of care and patient safety (Castronovo, Pullizzi, & Evans, 2016; Trépanier, Fernet, Austin, & Boudrias, 2016). Such culturally embedded negative workplace behaviours need organisational attention.

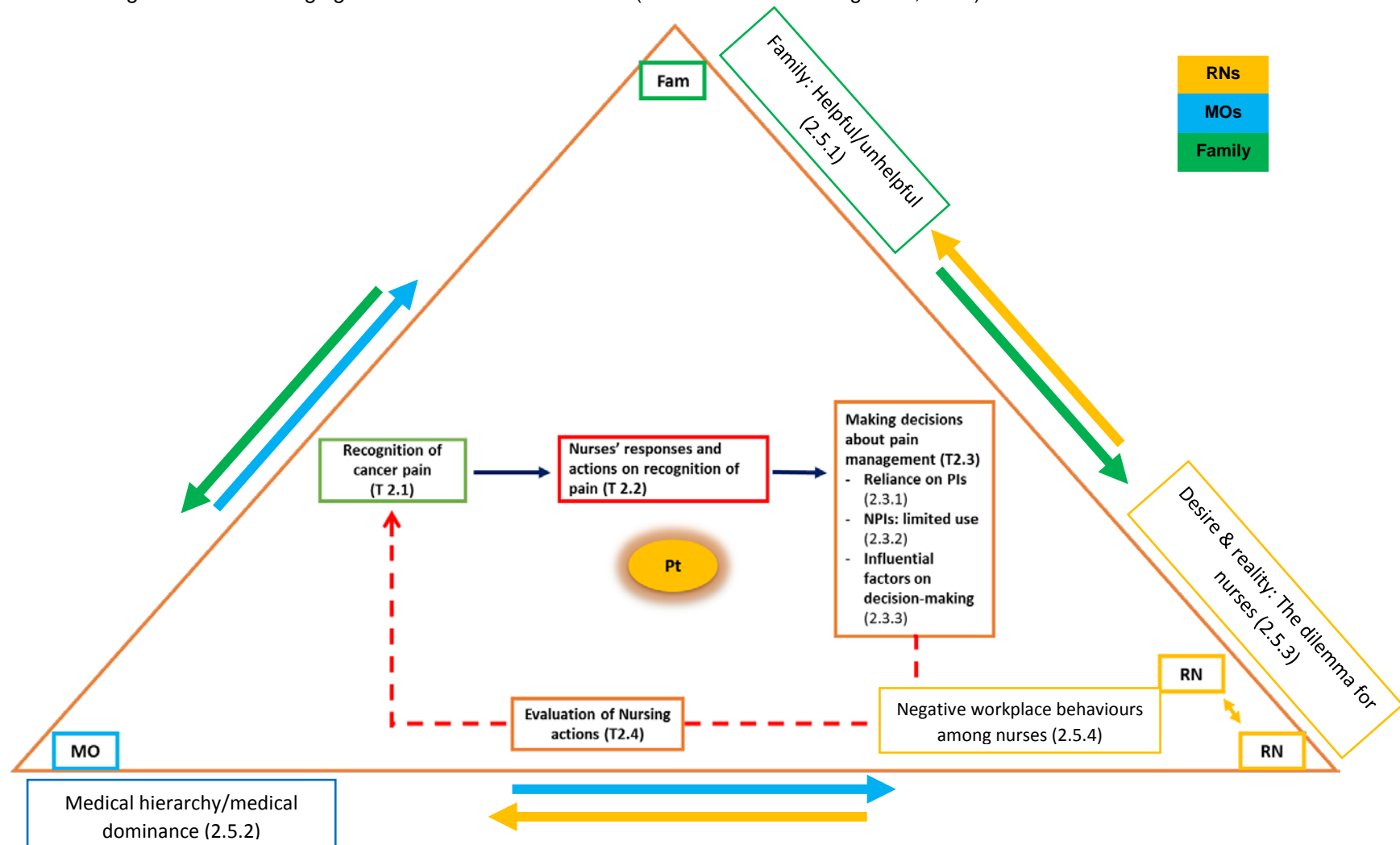
A focus on workplace culture should include development and implementation of a strategic approach to prevent negative behaviour. Also improving communication processes and protection of the victims of bullying should be part of strategies developed at organisational level.

5.2. Issues related to Nurses and Patients/Families

The nurses' usual practice is captured and presented under ST2 in Chapter Four with six themes and fifteen subordinate themes. Reflecting on the analysis and synthesis of the nurses' usual practice led the researcher to identify the actual processes and relationships between the themes and subordinate themes, and to develop a framework (See Figure 5.2) that was modified from Dowding et al.'s (2016) framework, 'hypothetico-deductive reasoning'. Development of the framework enabled the researcher to further interrogate, interpret and come to some conclusions about the data from observations and interviews, especially around the nature and extent of the nurses' roles and functions in managing cancer pain as outlined in Figure 5.2. These extrapolations from the data are now elaborated upon, as they have implications for future directions in nursing practice.

As described in the finding chapter and recaptured in Figure 5.2, nursing practice was clearly influenced by various issues, when nurses made clinical decisions within a context that incorporated the existing relationships between patients, families, doctors and nurses within the organisation in which care processes were situated.

Figure 5.2. Nursing Practice in Managing Pain for Patients with Cancer (modified from Dowding et al., 2016)



The findings suggested that the participants did not always appear to be acting on decisions consistent with an advanced level of practice based on evidence, but rather seemed to adhere to a “Transactional approach” (Mirvis, 2012) to care. The level of care that the nurses provided for those patients with cancer to manage pain was varied and depended on the worldview of the individual nurse and the influences that were created from the existing relationships between all involved in managing cancer pain.

The processes and relationships identified in the framework have revealed two major issues; the value of the nursing contribution and an apparent undermining of the nurses’ role by all involved that subsequently caused inadequate management of cancer pain; and lack of patient-family centred care aligned with therapeutic partnership and mutual respect, which will be critically discussed as follows.

5.2.1. Nurses and their practice in cancer pain management

5.2.1.1. Valuing the nursing contribution

As presented in the findings chapter, nursing practice for managing pain among the patients with cancer was task-solving oriented, passive and often medically dependent. There could be several influential factors that underpin the current place of nursing practice in managing cancer pain including historical, social and cultural images of nurses; legal boundaries of nurses’ scope of practice; and the absence of a nursing framework for management of the particular symptom. Those factors are contributors to the conscious and unconscious undervaluing of nursing not only among MOs, patients/families, but also among nurses themselves. This negative profile of the profession is undermining positive perceptions of what nurses do in caring for those patients with cancer especially around pain management.

This phenomenon and behavioural traits may have originated and become embedded in the long history of the profession and its culture in Korea. Culture is a critical component in every person as it acknowledges every individual as a unique human being (Koffman et al., 2008). At the same time people in the same cultural group often share attitudes, values, beliefs and languages, which in turn is heavily influenced by the history of the society; they even share worldviews and the way they behave in relation to other people (Gilbar & Miola, 2015). Whilst the current Korean society has been rapidly changing and modernising, both patients and healthcare professionals including nurses are individuals within society who still share many cultural and social aspects that influence their attitudes and behaviours around pain management. As Lee (2000) described in her study, the perception of Korean society towards the position of nurses is that they are inferior to MOs; this view has been generated throughout the long history of professional health care. The nursing profession initially was considered as a women's job, one that did not require any professional knowledge and skills (Yi & Hwang, 1997). Koreans adopted a different approach to nursing by responding to a modernisation agenda between the late 1800s and early 1900s under the influence of Japanese and European influences in the first instance, followed by American influences later (Shin et al., 2013). During this time, a few 'Ginyeo (기녀)', which literally meant 'female entertainer', were recruited and trained to perform songs and dances to entertain the men from 'Yangban (양반)', the aristocrat class. They were also trained in a basic level of acupuncture and medicine in order to replace male medical personnel to look after female patients from the 'Yanban' class. This was due to the applications of rules for different genders in those upper classes such as prohibition of male doctors' direct care for female patients. Despite a new name, 'Uinyeo (의녀)', which literally meant 'female medical personnel', instead of 'Ginyeo' and being affiliated to the governmental office, they were still classified as in the lowest social class due to their origin, and the gender and power imbalance originated then and has become embedded since then (Koh & Koh, 2009; Yi & Hwang, 1997). Hence, they were still considered as insignificant even after they became 'Uinyeo' and

considered as in need of supervision from the male doctors. They were only allowed to do what doctors ordered them to do. Undervaluing nursing and the roles of nurses among all other involved parties in care for those patients with cancer who were experiencing pain was clearly illustrated through MOs' communication manners, patients/families' preference on reporting pain only to MOs, non-reimbursable nursing activities and nursing staffing subject to adjustment in any case of financial constraints within the organisation, as reported and discussed previously.

The implications of this are paramount and evident in the data from the interviews and observations. The nurses in this study demonstrated passive attitudes towards taking initiatives for potential change and creativity in their nursing practice including cancer pain management. There were indications that the nurses undervalued nursing and their own practice. The nurses often stated that their own desire for managing pain was not satisfied, but they could not make much change. Also, the nurses in this study did not actively perform ongoing screening and/or assessment for pain for those patients with cancer because they believed that patients would/should initiate report of their pain. This could limit the chance for the nurses to practice based on evidence that they should use to inform their clinical judgements. Nurses are often considered as passive, when they face problems (Cao, Chen, Tian, Diao, & Hu, 2015; Han & Ha, 2016).

This could be due to the traditional expectation of being nurses who would be submissive and passive (Henderson & Fletcher, 2015). However, as Foucault has emphasised, accepting anything as natural, necessary and unavoidable without critique can be dangerous, because it can result in power relations of static states of domination with limited validity and acceptance of thoughts and behaviours (Taylor, 2014).

The legal parameters that guide the scope of nursing practice also cause a tendency towards undervaluing nursing and hence undermining what nurses do. The 'Medical

Service Act', which is the primary legal boundary for all healthcare professionals including nurses, has been updated and the changes have been enforced since December 2015 (MHW, 2015). The updated version indicates "a nurse's obligation for observation of patients, data collection, nursing judgement; assistance in medical treatment under medical officer's guidance; education, counselling, planning and implementing care; and supervision of assistant nurses". However, the previous mission of nurses was "to nurse injured or sick people, or postnatal women, to assist in medical treatment and to conduct health activities as prescribed by Presidential Decree" (MHW, 2010b). This would be an important statement to be embedded in perceptions and attitudes among the more senior healthcare professionals including nurses in terms of their positions and roles in the healthcare structure. Hence this could impose the acceptance of medically driven development of the CPMG and nursing practice for cancer pain management. While the revision of the mission statement for nurses included some level of independence in roles of nurses around "nursing judgement, education, counselling, planning and implementing care", it is not clear how the nursing profession accepted and thus executes the roles and functions of nurses within their own understanding of practice. Their own profession through education reflects them as competent healthcare professionals within the current society and in their preparation for the future. It is important to note that although there is a recognition of the nurse as a competent healthcare professional in their own right in a particular situation, where there is a shortage of nursing staff, high levels of workload, and historically and culturally embedded hierarchical workplace culture, nursing roles and functions are limited to assist in medical treatment under MO's guidance. However, as an essential step to move forward, nursing academics and practitioners nationally and internationally have called for the Korean nurses' independent 'Nursing Law', which could give clearer guidelines about nursing practice against standards that ensure nurses are competent healthcare professionals (Moon, 2012). But more importantly, enactment of the 'Nursing Law' can become a symbol of legitimisation of independence and professional practice for nurses

against which the nurses will have to demonstrate fitness for practice with concomitant responsibility and accountability. This development can guide the establishment of a scope of more advanced practice for the nurses that could empower the nurses to practice as competent healthcare professionals at an optimal level rather than being medically dependent and/or remaining as supporting MOs.

Undermining the values of nursing and what nurses do was also evident in the absence of clear nursing frameworks in nursing practice for managing cancer pain in this study. The participant nurses seemed to renounce/limit their own rights as competent healthcare professionals, because they did not have the right to prescribe medications. Unlike elsewhere in the world for NPs this medication function was not within their scope of practice. This however could indicate their lack of understanding of their own scope of practice and the potential that they could have initiated extended practice roles in some situations. Some nurses in the study stated that they valued the nursing related concepts and wanted to use those nursing concepts in their own practice rather than just following medical officers' orders. Although some nurses present themselves at interview as practising a full suite of nursing-oriented concepts that enhance therapeutic relationships and care, it was often not obvious within observations that such concepts were well established in their own practice. For example, the nurses still frequently turned to the MO without visiting and/or attending assessment to find out the nature of the situation, for example when patients complained of pain. Assessing the patients' needs using nursing knowledge and processes for finding and taking the appropriate actions to meet the patients' needs might include the report to the MOs for their medical interventions. However, there are distinguishing points between professional nursing care and general care that non-nurses can provide (Royal College of Nursing, 2014). It is critical to use a nursing framework with reflexivity in their practice in order to provide consistency in their practice by enhancing communication. In this way they can ensure nurses continue to have systematic approaches that inform nursing education, practice and research.

5.2.1.2. Inadequately managed cancer pain: A cause of suffering for both patients and nurses

Given the apparent lack of EBG use in decision-making, and ingrained knowledge, behaviour and shared understandings and assumptions among the nurses in the historical, cultural and socio-political context of the Korean acute healthcare settings such as those in the present study, it was inevitable that the patients' pain was often inadequately managed. As a result, the appraisal of nurses' experience of cancer pain management in the context of Korean healthcare setting showed that patients were suffering from pain with implications for a decreasing quality of life. Consequently, this inadequately managed pain caused the nurses to suffer themselves with a sense of professional dissonance; this led to a cycle of poor nursing practice and patient outcomes in managing pain.

As presented in the finding chapter, nurses' experiences of managing cancer pain had implications involving the following key aspects.

- *An examination of practice revealed professional limitations and responses from nurses reflecting negatively expressed as anger and frustration.*
- *A mapping of the terrain of the professional responses to pain revealed a gap between the aspirations for quality pain management and the practices of nurses.*
- *Consequently, the nurses experienced a high level of professional dissonance leading to a disconnection from providing optimum care during the cancer pain management situations as a way of rationalisation for their professional conflict.*
- *There is a clear need to fill the gap between the usual practices of nurses and the aspirations for new ways to achieve optimal management of cancer pain through adherence to the guidelines.*

The participants clearly expressed their aspirations for quality care to minimise/ease the pain that those patients with cancer were experiencing, but the descriptions of their own practice often illustrated the gap between their aspiration and their actual practice. The participants reported their unsatisfying nursing practice was due to situations which they

could not change, such as a lack of time for direct patient care with excessive workload and the hierarchical relationship that limited nurses' right to make decisions. Given the historical and social background of the relationship between nursing and medical personnel, along with all other influencing factors, nurses in Korean healthcare settings are often expected to be submissive and passive.

Nurses often present themselves as having such ingrained expectations reflected in their perception and it is often represented, for example, in nurses' choice to be silent regardless of disagreeing with MOs' decisions. Despite the extent of nurses' presence at the bedside and the volume of time they spend with patients, which in turn increases the chance of seeing the clinical issues, nurses are often unable to, but also decide not to, speak up about their concerns/opinions. Kim and Oh (2016) conducted a grounded theory study to provide explanations of nurses' communication processes in a Korean healthcare context. They found that the nurses learned to be silent and assimilated into the hierarchical culture in order to become and/or belong to a part of the care team including senior nurses. Price, Duffy, McCallum, and Ness (2015) sought the reason why nurses tolerated suboptimal quality of care, from the perspective provided by a social theory of conformity; the nurses used conformity to become and/or belong to a part of the nursing team. They further cited that it was more likely to happen when the nurses lacked knowledge, but even the nurses who were confident in identifying and resisting the causes of suboptimum quality of care, illustrated some level of conformity in their nursing practice. Within such a hierarchical working culture and medically dominant healthcare structures, nurses can easily comply with established practice and ward routines, even if they have been taught to question practice, in order to fit in and be accepted.

However, nurses experience distress/professional conflict and professional dissonance, when they are unable to perform their nursing practice within their professional standards

for various reasons (Carnevale, 2013; McKimmie, 2015). The participants in this study reported their powerlessness and frustration when they faced limitations in making decisions and performing practice that achieved positive patient outcomes, and/or had to follow MOs' orders regardless of disagreeing with MOs' clinical decisions; hence witnessing patients' ongoing suffering from unresolved pain-related issues. Ongoing experience of professional dissonance can lead nurses to disengage and/or keep a certain distance when providing quality care, as a way of protecting themselves from the great emotional costs such as frustration (LeBaron, Beck, Black, et al., 2014).

For example, the negative emotions including anger and irritation that the participants experienced, because they could not embrace the unique characteristics of individual patients, could be the outcome of professional dissonance. As described in the findings chapter, the nurses came to conclusions about the patients with extreme complaints and/or demands in relation to pain as being sensitive and non-compliant, without attending to a comprehensive assessment to find the actual cause of pain and/or providing interventions that targeted multidimensional aspects of pain. This occurred despite the essential element of patient centeredness in nursing care for managing cancer pain. Such patient' characteristics that the nurses described as being sensitive and/or non-compliant could also be a reflection of their levels of anxiety, which was elevated by the severity and frequency of pain. Without an in-depth understanding of each patient through comprehensive assessment based on a PCC concept, the nurses cannot provide reflective care for those individual patients. They rather easily focus on completing the given tasks to claim that they have fulfilled their responsibilities as was their duty. If the nurses understood the patients and their experience better, they could have considered other possibilities that could exacerbate the pain and/or pain behaviour (de Albuquerque & de Mattos Pimenta, 2014; Matthie & McMillan, 2014), and tested out different approaches to identify the best intervention for the patients. Interestingly, the nurses interpreted such sensitive non-compliant behaviour among the patients as the

reflection of their lack of trust towards nurses. Although it may not be appropriate for the researcher to conclude if the patients had extreme characteristics and/or did not trust the nurses with the limited data; it is clear that the given nursing care did not meet the patients' true needs in managing cancer pain and consequently the therapeutic relationship between the patients and the nurses was negatively impacted.

As de Vries and Timmins (2016) emphasise, nurses reduce their professional dissonance by convincing themselves that their suboptimal care in managing cancer pain is not due to their limitation. The nurses identify external barriers to justify their choice of suboptimal care. Whatever the nurses have found that works for reducing their professional dissonance, they are highly likely to use again, when they face similar situations. This outcome unfolded as a widespread trend of accepting the experience of pain among the patients with cancer as taken for granted. The intervention provided should have been enough. If they were to look into their professional mirror they would have been better able to face the patients' true needs. This failure to reflect on the consequences of their practice ensured the ongoing nature of the vicious cycle of patients suffering pain and nurses suffering professional dissonance.

The nurses' shared experience of caring for those patients with cancer who were experiencing pain clearly showed a need to fill the gap between their usual practice and the aspirations for new ways to achieve optimal management of cancer pain. Therefore, an integrated approach to using evidence-based cancer pain management would be required in an effort to bring about change at different levels. This will be discussed in Section 5.3.

5.2.2.Call for patient-family centred care: Aligned to therapeutic partnership and mutual respect

Given the clear definition of pain as a subjective personal experience PCC in cancer pain management has been introduced and encouraged for nurses in various settings in Korea (Kang & Suh, 2015). However, the observed and reported nursing practice in this setting included making assumptions about patients' pain without adequate assessment and evaluation of pain, and documenting nurse interpreted pain scores in the EMR system; this indicates a lack of patient centeredness in nursing practice in managing pain for patients with cancer.

The study findings indicated that the nurse participants' mistrusted patients' self-reports of pain, especially when patients did not show non-verbal expressions such as grimacing faces, and the nurses' own misconceptions about the use of opioid analgesics also commonly hindered PCC. The nurses often presented with prejudiced attitudes towards accepting the patients' self-reporting of pain by giving higher pain scores for those patients with a grimacing face, whilst giving lower pain scores for the patients without non-verbal cues.

Furthermore, as reported by the nurses in this study setting, nursing practice of pain assessment was based on their limited perceptions and lack of understanding of cancer pain rather than patient-centred comprehensive assessment. For example, as Jinhee reported, the nurses also seemed to have an expectation that cancer pain should be severe as cancer is considered as one of the complex and life threatening diseases (Donnelly, 1995; Kasasbeh, McCabe, & Payne, 2016). This in turn could easily have caused the nurses to undervalue or ignore the mild to moderate pain by rationalising that pain is part of the disease process and/or that treatment of the cancer is more urgent as it is considered the way of ensuring patients are free from the disease or at least

prolonging their lives. As reported, this perception has limited the nurses in this study from paying attention to less severe pain, although preventing and/or managing pain at an early stage is critical in terms of improving patient outcomes. It is well documented that there is significant increment of pain among patients with cancer in both severity and frequency, as the disease progresses and/or treatment progresses (Van den Beuken-van Everdingen et al., 2016).

The above finding is consistent with other studies. Several studies reported that such misbeliefs about cancer pain management lead to a decrease in nurses' attending to pain assessment (Al Khalaileh & Al Qadire, 2012; Bernardi et al., 2007; Chang et al., 2005; De Silva & Rolls, 2011). It clearly indicates that nurses' perception of cancer pain needs to be improved in order for the nurses to be more patient-centred and sensitive to managing pain for the patients with cancer.

The concept of patient-centeredness is the core value in caring for patients with cancer including symptom management such as pain (Kitson, Marshall, Bassett, & Zeitz, 2012). The concept aims to cause clinicians to make decisions to meet an individual's specific health needs and desired health outcomes through providing adequate information and inviting the patients' participation in their own care (Jo Delaney, 2018). There have been attempts made to adopt PCC in South Korean healthcare settings since 2000 as the society enters the era of the service-oriented industrial society that places the customer at the centre (Chae, 2014). This was a significant advancement given that the disease-centred model has underpinned healthcare system in Korea for several decades due to the low rate of contributions collected by the insured and government subsidy to provide universal health care to all (Bae, 2017; NHIS, 2014). Under this model, patients are partners with their health care providers, and providers treat patients not only from a clinical perspective, but also from an emotional, mental, spiritual, social, and financial perspective (Jo Delaney, 2018). This is consistent with the concept within a nursing

framework that places the patients as the ones who can decide on their experience of pain including its presence, severity and relieving factors (Masters, 2015). This approach provides a good rationale outlining a need for partnering between patients and healthcare professionals, particularly the nurses, in order to optimise the patient outcomes.

One might say that individual nurses are responsible for their actions in practice. As Innis, Bikaunieks, Petryshen, Zellermeier, and Ciccarelli (2004) emphasise it is nurses' ethical responsibility to provide adequate care. Nurses' adequate level of knowledge and skills for managing pain among patients with cancer should be considered as prerequisites for holistic PCC (Karlou, Papathanassoglou, & Patiraki, 2014). Surely, individual nurses should demand and seek opportunities for the most up to date information and education as evidence of participation in continuing professional development; 8 hours⁴ per year is a mandatory requirement for those nurses who are currently practising to renew their registration in Korea (MHW, 2017).

The patients were at the centre of nurses' practice, and their families in this study setting were clearly visible within nurses' usual practice for managing cancer pain. This is in alignment with the concept of the PCC which invites patients to participate in their own care and they certainly have an active role in the care delivered to them. In addition, family involvement in managing pain among those patients with cancer is an essential element in the context of Korean healthcare, as it has a strong cultural influence from family collectivism and Confucianism (Rha, Park, Song, Lee, & Lee, 2015). It is not unusual to see patients who even have expectations for their family members to make medical decisions for them, when they are seriously ill (Ham, 2004). As emphasised in

⁴ Different hours for continuing professional development are applied depending on the length of time off-duty, up to a maximum of 20hours per year.

the findings chapter, it was not hard to see that family members were involved in direct patient care at the bedside by assisting with activities for daily living and updating nurses with the information for any changes in response to the given treatment (Kwon, Hattori, Lee, & Kim, 2015; Lee, 2015a).

Unfortunately, the nurses in this study reported numerous cases of patients and their families' inadequate pain reporting behaviours; this usually tended to be under-reporting, inappropriate use of the numeric scale, or mistrust and undervaluing of nurses by having a preference to report to only MOs, even though the nurses were physically closer. These patient-related behaviours revealed their lack of knowledge, misconceptions and negative perceptions towards cancer pain and their strong demand/desire for and reliance on pharmacological interventions only. This is consistent with a systematic exploratory review by Jacobsen, Møldrup, Christrup, and Sjøgren (2009) that aimed to explore patient-related barriers to cancer pain management. Patients' cognitive barriers such as knowledge, beliefs and attitudes could have a negative influence on patient outcomes in managing pain by reducing communication and reports of pain. On the other hand, frequency of reporting pain and preference in reporting only to certain healthcare professionals could be those patients' preferences. However, the onus is on nurses to educate and empower patients to meaningfully communicate their needs to healthcare professionals including nurses, and to participate in decision-making in order to achieve desired outcomes in cancer pain management.

The study revealed that families have significant influence on patients' perception, knowledge and attitudes, which eventually influenced patients' care. This is consistent with the finding from other studies. For example, Saifan, Bashayreh, Batiha, and AbuRuz (2015) found that family caregivers who have misconceptions about factors such as addiction, tolerance and disease progression tend to play a strong decision-making role in discontinuing certain analgesics. The patients and their families in this study have

fatalistic ideas towards cancer pain, such as considering pain as an inevitable part of cancer and believing cancer pain cannot be relieved with any intervention; these ideas have the potential to contribute to ineffective pain management among those patients with cancer. It was also evident from the studies cited above, that the families have limited knowledge, inadequate attitudes and negative perceptions towards cancer pain and its management; this prevents them from representing the patient's best interest.

This is not surprising; as also reported by the nurses in this study, the patients and their families lacked educational opportunity, and the written material for information was not continually provided despite the requirement for and achievement of accreditation. This implies that the partnership between patients, families and nurses consistent with the concept of PCC is essential in managing cancer pain. Providing adequate education/information to the patients should be the first step of PCC and patients should be empowered in terms of managing their cancer pain. Including family within PCC would lead to a more culturally and socially sensitive practice in Korean healthcare context. Education should target not only patients themselves, but also family members if nurses are to enhance the patient outcomes. The study highlights the importance of improving family understanding of different pain issues, which can ensure the family caregiver becomes a more accurate informant in terms of acting as a part of the care team for patients with cancer (Saifan et al., 2015).

Patients/families are often recognised as the most vulnerable group in terms of having personal power, whilst the highest rank in society is given to the medical officers particularly the consultants followed by nurses (Formosa, 2015). However, given the increasing numbers of voices for patient rights, competition among healthcare settings and implementation of the concept of service in healthcare systems, patients and their families have become stronger and more influential than ever before (Rha et al., 2015). Expression of aggression can be the way patients and their families act out their power,

when their needs are not met, although it would not always be recognised as an appropriate way. For example, the nurses in this study reported that there were some patients/families who became aggressive towards nurses, when they did not receive satisfactory updates on progress and treatment from MOs. In addition, the nurses were expected to tolerate patients'/families' aggressiveness with the concept of service in mind. This notion of service is inappropriately extended to emphasising patient rights. Having service in mind appeared to be misinterpreted as a tacit request to and/or approval of tolerating patients' excessive demands (May & Grubbs, 2002) sometimes including patients' aggression. However, it is evident that family aggression prevents maintaining therapeutic relationships between nurses and patients/family as it can have a negative influence on nurses' psychology (Fafliora et al., 2016). Encouraging and empowering patients and families to be involved in PCC should not be understood as permission for them to present with any unacceptable behaviours including verbal and physical aggression. It should be understood that is an alignment between the ideas of therapeutic partnership and mutual respect between patient-families-nurses.

Communication among healthcare professionals and with patients/families in the dynamics of all involved parties, is another essential element of providing optimum care and pain management for those patients with cancer. The communication style of each healthcare professional group should be taken into account and reflected upon. Interactive communication between MOs and nurses are acknowledged as key steps in obtaining patient safety and care quality by enhancing teamwork (Zwarenstein & Reeves, 2002). The study further emphasises that failure of interactive communication between healthcare professionals could result in practice errors, failure in obtaining/maintaining patient safety and difficulty in maintaining therapeutic relationships with patients due to the unsuccessful establishment of trust. Some of the participant nurses described the MOs' manner of communication as commanding and/or directive rather than

communicative; this prevented them expressing their concerns and/or opinions about patient care in relation to pain management.

In an ethnographic study of Pavlish, Brown-Saltzman, Jakel, and Rounkle (2012), trust working relationships with MOs, communication opportunities and nurses' self-confidence significantly influence nurses' choice about speaking up or remaining silent. This emphasises the importance of a work culture where the healthcare professionals, particularly nurses, can voice their concerns and opinions without fear and hesitation. Also, it indicates that there is a need for nurses to strengthen their self-confidence through changing the attitudes towards their own profession and performing acts that lead to professional growth. Communication is considered a fundamental element of working as a part of the healthcare team in order to ensure patients' safety and quality of care (Omura, Maguire, Levett-Jones, & Stone, 2017). Park and Chung (2016) reveal that communication competence has a strong influence on nursing performance especially when nurses act as advocates for patients. Thus, it is recommended that the organisation develop and implement an educational program for nurses to enhance their communication competence. This could be one of the useful strategies for the nurses in this study setting, as they appear to withdraw from opportunities for expressing their own opinion as a member of the care team. Moreover, as Williams et al. (2015) suggested, mentorship and education should be used to enhance positive behaviour changes among nurses in terms of enhancing patient-centred communication in managing cancer pain, rather than hierarchical approaches in which managers and senior staff in nursing lead from the front. The integration of organisational support, multidisciplinary collaboration and incentives/rewards could also be the elements that the organisation could rely on to make improvements in order to enhance quality and patient safety by encouraging improvement in their communication skills.

5.3. Final Statement of the Thesis

What this study has revealed is the extent to which RNs working in a Centre for Cancer Care in South Korea have capacity for appropriate management of symptoms of pain experienced by cancer sufferers. Within the wards within the Centre, besides providing the usual nursing care for patients with cancer, they are expected to

- 1) carry out a co-ordination role in the data collection about Pain Management.
- 2) provide a level of care around pain management that accommodates the complex and shifting nature of patient needs within the setting.

The development and introduction of the CPMG, considered as the innovation to guide the management of pain in patients with cancer in healthcare settings in South Korea was warranted but, as evidenced in this study, only partially implemented. The study investigated the impact of the introduction of the CPMG on nursing practice in South Korea healthcare context. Chapter Four presented findings around answers to questions of 'if' and 'to what extent' the CPMG was implemented, and provided comprehensive descriptions of personal nursing practices within the experiences with cancer pain management since the introduction of the CPMG. The researcher employed critical theory to analyse the findings, and discussed the historical, cultural, economic and political context where the nursing practice was situated with an emancipatory intent to facilitate further actions and changes.

The data from the interviews and observations of nursing practices in three units within the Centre highlighted limitations in the extent to which the professional organizations and developers of guidelines (e.g. as expressed in recent Korean CPMG) had made explicit the nurse's advanced role in professional activities that place the patient at the centre of cancer pain management strategies. The subjugation of the nursing role in pain management and the nurses' unquestioning subservience was evident in the study. The nurses in this study did not give primacy to the patient with cancer and pain and they did

not devise therapeutic or helpful nursing interventions underpinned by contemporary evidence for best practice in pain management.

The study has revealed that optimum care for cancer pain management cannot be achieved by the introduction of a single innovation, a national level directive for application of the CPMG, especially if the organisation and the individual adopters are not ready or assisted to adopt the strategy in a meaningful way. There were a number of systems and elements employed in the process of implementation of the CPMG which had not been integrated in the study setting.

The following Table 5.1. summarises the issues that have emerged from the study, and the implications/recommendations for practice development in nursing and research.

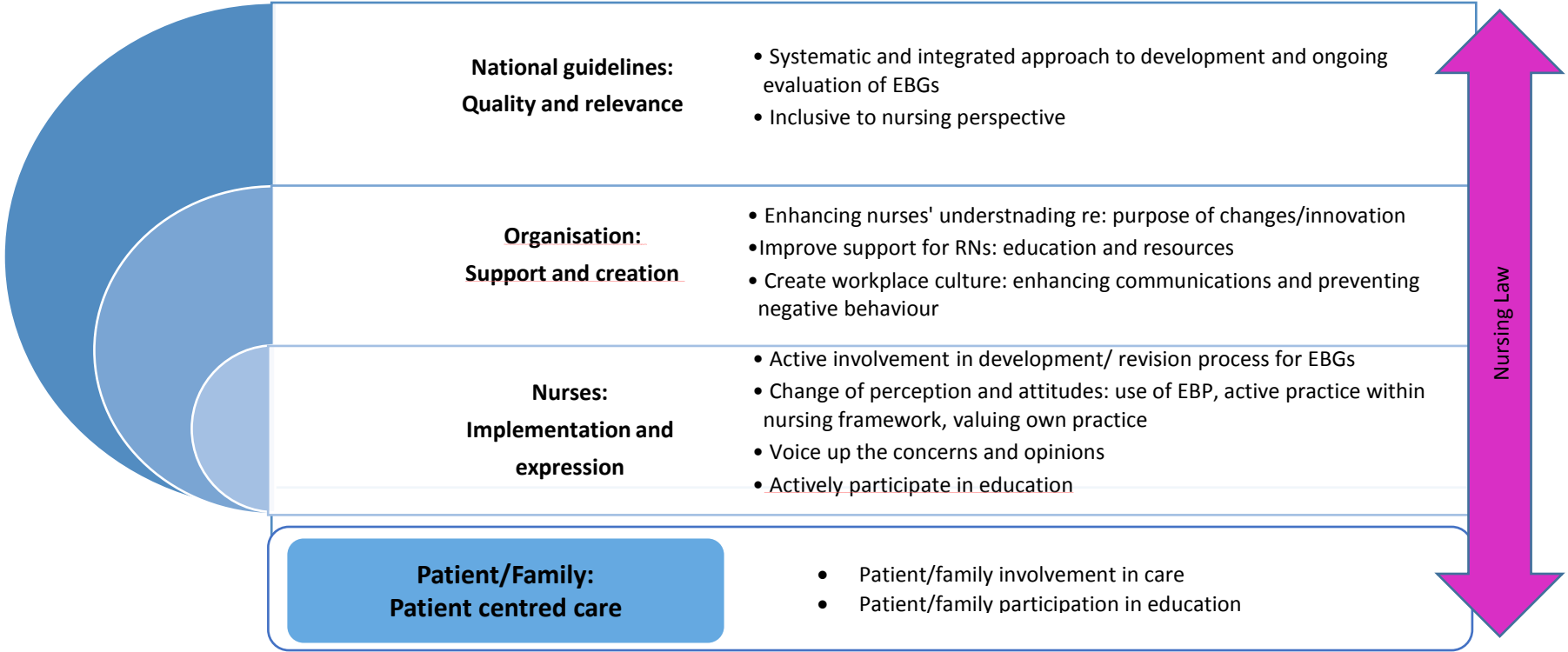
The study has revealed reactions to changes at different levels: Policy that informs the development and reviews of national guidelines; within the service delivery in the organisation; from nurses; and patients/families responding to patients' health issues and cancer pain management. While Greenhalgh et al. (2008) proposed a conceptual model for the diffusion of innovation in organisations, this study has identified and added new knowledge about the nursing response to guidelines. It is suggested that an integrated approach to cancer pain management is required to address issues at all four levels; the national, the organisation, within nursing and at the level of patients and their families.

Table 5.1. Summary of Issues and Implications

| | Issues | Implications/recommendations |
|-----------------------|---|--|
| Guidelines | Level of the CPMG and/or NTGB as EBGs | Following a systematic development process |
| | Lack of relevance in nursing practice | Involvement of more nurse clinicians and academic groups in developing and updating the CPMG |
| Organisation | Lack of understanding about the purpose of changes (adopting innovations) | Shared understanding on purpose of adopting the innovation |
| | Inadequate resources in both material and human | Providing adequate level of resources (human/material) |
| | Lack of opportunities for relevant education/training (both RNs and patients/families) | Providing relevant education/training (RNs and patients/families) |
| | Negative workplace culture - hierarchical relationship, and bullying | Creating receptive and supportive workplace culture for adopting innovation, interdisciplinary collaboration |
| Nurses | Passive and medically dependent nursing practice | Active involvement in their own practice (taking ownership) |
| | | Use of nursing framework with reflexivity |
| | Passive attitudes towards taking initiatives for potential changes and creativity in nursing practice | Actively taking initiatives for potential changes |
| | Traditional expectations for nurses: submissive/passive; RNs: unable to and/or deciding not to speak up about concerns/opinions | Active participation in giving feedback on EBGs |
| | | Expressing concerns and opinions |
| | Passive attitude towards participating education/training: A lack of knowledge | Active involvement in participating education and searching for information |
| | Current Medical Law - limiting nursing practice | Enactment of the 'Nursing Law' |
| Patient/family | Making assumptions about patients' pain without adequate assessment/evaluation; Use of RN interpreted score for documentation | The concept of patient-centeredness in nursing practice |
| | Unhelpful family influence on patient care including decision making; Expression of aggression | Involvement in the process of patient care with mutual respect and therapeutic partnership |

The suggested integrated approach to evidence-based cancer pain management is presented below, depicted in Figure 5.3 and recommendations italicised in the following discussion.

Figure 5.3. *Integrated Approach to Evidence-Based Cancer Pain Management*



5.3.1. Recommendations for practice development in nursing

First, the quality of the processes behind the development and uptake of national EBGs need be based on evidence in order to provide EBP in managing cancer pain amongst those patients with cancer. Given the pre-assimilation stage of the implementation of the CPMG and suboptimal quality of the NTGB that guides nurses to make evidence-based clinical decisions, there is at least one necessary additional step required. The fundamental additional step is ***to undertake a systematic and integrated approach*** in synthesising the evidence to apply into the practice through revising the existing CPMG and/or NTGB. Along with ensuring the quality of the guidelines is at an acceptable international level for EBGs, the content of the guidelines should be made meaningful to the nurses by extending to them the opportunity for inclusion of ways of improving relevance to PCC. Meaningful but practical approaches to implementation are needed. Critical reviews of recommendations need to be extended to cover not only pharmacological issues but also various non-pharmacological interventions to help clinical processes among the nurses to provide adequate care based on considered judgements about and with those patients with cancer who are experiencing pain.

Nurses, as one of the stakeholders of the EBGs, need to assert their role in relation to managing patients' pain and ensure the EBGs are reflective of nurses' practice through participating in guideline development/updating processes. This can ensure an outcome that features and/or improves the relevance and practicality of the EBGs to nursing and PCC practices.

Second, the organisational roles, particularly the personnel in the managerial levels, in diffusion and implementation of EBGs is critical. The organisation needs to have adequate understanding about the innovation, such as implementing EBGs and the purpose of adopting the innovation, in order to ensure the understanding of changes among those healthcare professionals, particularly in this case, the nurses. The ***primary***

purpose should focus on improving the quality of care and patient outcomes, rather than promoting organisational reputation, as the latter could be achieved once the quality of PCC is enhanced. It is a responsibility of the organisation to adequately ***support the nurses by creating opportunities for them to have the necessary and relevant education and training around their role in contemporary nursing practice.***

The support for education and training should reflect the relevance to contemporary professional level nursing practice. For example, the organisation is responsible for providing intensive education and training during the time of changes such as adopting the EBGs. Also, the organisation has to develop and provide regular and continuous education and training for cancer pain and its management for the nurses in order to obtain and apply current evidence-based knowledge and skills. ***Providing an adequate level of necessary human and material resources*** is an essential role of the organisation in terms of improving quality of care and patient outcomes for cancer pain management, as they are the essential elements of system antecedents for spreading the innovation that is adopting EBGs. Recruiting and retaining sufficient number of nursing staff and training in pain management for specialised nurses, who can take a role of knowledge purveyors, is a fundamental organisational role. Moreover, raising staffing related issues by bringing these to the attention of governmental level personnel as an organisation and supporting the nursing groups who raise their voices on staffing issues, are central to the organisation's responsibilities. This is critical in an effort to improve support for those nurses and hence patient outcomes in managing cancer pain. Material support in managing cancer pain is as important, as this can enhance the use of various options of interventions beyond the pharmacological. ***Creating a workplace culture which is receptive to and supportive of the implementation of EBGs in nursing practice*** by encouraging the MOs and leaders to be open to the general nurses, and ***giving more opportunities for communication*** and ***preventing the occurrence of negative behaviour in the units by establishing regulations,*** are the organisation's responsibility for enhancing system readiness.

Third, ***nurses must be actively involved and take ownership of their own practice;*** this is critical to improving nursing practice for cancer pain management. Nurses often become task-solving oriented, passive and medically dependent, due to several underpinning factors such as historical, social and cultural images of nurses and the absence of a nursing framework for cancer pain management and this contributes to nurses' attitudes of devaluing/undervaluing their own practice. Devaluing/undervaluing the profession can oppress the nurses even more (Bruresh & Gordon, 2006), hence ***changing attitudes towards their own practice as distinctive healthcare professionals and practising actively under nursing frameworks should inform their worldviews.***

Along with the organisation's effort to create a workplace culture which is receptive and supportive through encouraging more opportunities for communication and reducing the negative behaviours, ***nurses should not be afraid of taking initiatives for potential changes and creativity*** in managing cancer pain. Within their workplace culture, they can support and encourage the adoption of EBP in their nursing practice through the greater use of EBGs.

Although this study is limited around making in-depth recommendations on the roles of nurses in managerial level as the researcher has not interviewed them, it is clear these managers also need to take on some distinctive initiatives. For example, as some participants have highlighted, the managers and leaders should become the role model for active and reflective practices. It is their role to be actively involved in the process of developing/revising nurse targeted quality EBGs for nursing practice in managing cancer pain. While the ***nursing academics and leaders are participating in the actual development/revision, general nurses can express themselves by actively giving***

feedback through the nursing academic associations/societies, to which they are affiliated.

Nurses also need to express their difficulties and concerns faced, as well as ideas that they consider to be positive, during patient care in managing pain for patients with cancer. Although nurses have been expected to be less active and/or passive as per social norms, it would be the nurses along with those patients who would be suffering when suboptimal quality care continues in managing cancer pain. Hence, it is time for nurses to express themselves by giving **voice to their concerns and opinions in a professional manner**. It is essential that the nurses use critical reasoning skills to enhance reflective practices based on evidence, for their voice to be heard by other healthcare professionals, patients and families, organisations and even the public.

Moreover, obtaining adequate knowledge about and useful attitudes towards cancer pain and its management through **actively participating in education and searching for relevant information** can give confidence to nurses to competently implement EBGs, and express their own concerns and opinions.

Fourth, **the concept of PCC embraces patients and their families as being at the core of caring** for those patients with cancer who are experiencing pain. Although there is a concern that the principles of PCC, such as focusing on patient needs and preferences, can be easily neglected in the process of implementing EBP (Bensing, 2000), practising with the aim of PCC in conjunction with EBP is critical. Both PCC and EBP are aiming for improvement in patient outcomes (Burman, Robinson, & Hart, 2013) and empowering patients; this can be beneficial in terms of achieving long term goals of owning the care (Formosa, 2015). This indicates that the purpose of implementing EBP can be truly achieved, when the nurses practise within the concepts of PCC. Despite the benefits of implementing PCC into nursing care, there could be gaps, given the patient

may not have the right resources to actively participate in making decision for her/his own care in managing cancer pain (Verhaegh et al., 2017). Nurses can minimise such gaps through providing ***adequate education and information***. Moreover, ***asking/offering for the involvement of representative family members into care processes with mutual respect***, including setting the care goals and plans, would lead to more sensitive practices within the Korean healthcare context.

Finally, it is critical to ***continuously work on achieving an independent 'Nursing Law'*** in order to promote nurses as able to take independent roles as healthcare professionals. As Kim, Kjervik, and Foster (2013) point out, it is not surprising to see medically dependent nursing practice under the current legal boundary, as it has been established based on paramedical ideology instead of professional ideology. However, achieving a 'Nursing Law' that is based on nursing professionalism can ensure nurses practise based on evidence rather than being medically dependent and/or driven by a negative workplace culture.

Recommended roles and functions of all nurses in managing pain for those patients with cancer can be derived from the above recommendations.

- As a clinician: observing, measuring and asking relevant comprehensive questions for assessment; preparing patients for scheduled treatments and procedures, supporting and maintaining normal functions and process and preventing breakdown of physical/behavioural care; and structuring an interactive and emotional environment.
- As a manager: evaluating the patient outcomes, making judgements, organising interventions, planning goals/care and leading/directing.
- As a communicator: recording EMR including pain score, reporting pain-related issues to MOs, conveying messages and discussing with MOs.

- As a researcher: evaluating the patient outcomes, collecting data to improve quality of care, critically analysing, and looking for evidence-based care options.
- As an educator: providing information, advocating, and teaching.

5.3.2.Recommendations for further research

South Korean nurses need to identify what constitutes 'best practice' in cancer pain management locally and elsewhere. Collaborative studies across sites would provide incentives for change. Action-oriented or practice-based research could lead to the development of some principles needed for guiding policy implementation around cancer pain management. Again, these might arise from comparative/cross cultural studies and the development of some Nursing Conceptual Frameworks for Pain Management that could be tested in an interdisciplinary environment.

Along with the research on developing 'best practice' for cancer pain management using EBGs, this study recommends extending research on the following issues. As this study identified, nurses' practice was medically dominated and this had a negative impact on optimising the quality of care and patient outcomes as it limited nurses' active responses to patients' true needs. Research can be focused on searching for the way for nurses to understand and improve the true value of their own practice and its effects on the care they deliver. Conducting research on an interdisciplinary team approach in managing cancer pain can enhance nurses' understanding about their roles and about becoming a part of the healthcare team.

Third, patients' families had significant roles in caring for patients with cancer pain in Korean culture. However, their aggression and discriminative behaviour, including reporting significant changes and issues only to MOs, was shown to have a negative influence in terms of providing quality care for the patients. This requires a further in-

depth investigation to identify the underpinning factors that caused such behaviours, and the impacts on nurses/nursing practice and ultimately patient care/outcomes. Moreover, action-oriented research could lead to the development of patients/family education resources to encourage them to be involved in the patient care as a partner and to work with nurses who are at their bedside 24/7.

5.3.3. Limitations of the study

- The researcher conducted the study in three different units in one acute hospital setting. Therefore, the findings of the study need to be interpreted with caution.
- Only ten RNs were included in the study. However they were a representative sample in terms of their ages and experiences. In addition, the final sample size of ten RNs was adequate and enabled data saturation to fully analyse the phenomenon.
- The study has identified in-depth views and beliefs of nurses in managing cancer pain. The study has also revealed that patients, families and MOs are significant players in the context. Multiple additional perspectives including those of patients, families and MOs will be useful to add further insights into optimal cancer pain management.

5.4. Final Reflections on the Study

Throughout the journey of my study, I had to take thousands of little steps with reflections on various ideas and issues including the process of conducting research on nursing practice when the suggested changes were meant to improve the quality of care and patient outcomes, particularly in managing cancer pain.

While I observed and heard a lot about changes in pain management practice and the healthcare system in the South Korean context, my personal experiences indicated that, nurses' practices had not changed a great deal from my beginning level days as a nurse in South Korea. It seemed that, despite significant changes especially in terms of the study settings, the uptake of technology to support health services and the introduction of the CPMG, this did not impact on improvement in approaches to patient care, especially by nurses.

At the outset of my study, I assumed that there would be some evidence of the impact of the guidelines on nursing care, given that seven years had passed since the introduction of the CPMG at the time of the commencement of this study. For example, during my own time practicing as a nurse before I left South Korea in 2003, it was common, accepted and acceptable practice to use placebos in order to verify the presence and severity of pain reported by patients. At the time of the study within this study setting, some participant nurses reported that the use of placebo was diminishing; they reasoned that the Vice President of the Cancer Care Centre had a background in palliative care and advocated against the use of placebos. Although I personally did not observe the administration of placebos to verify/manage pain in this study, some participant nurses reported that they were directed by MOs to give a placebo. As the findings of this study revealed, unfortunately many of the nurse participants, did not see this as an anathema or problematic in terms of optimal pain management.

Among the 10 participants, there was a level of interest in optimal pain management, hospice care, the informed involvement of families and using a range of nursing interventions beyond the administration of medications. However, even the nurses were aware that their level of care delivery was often sub-optimum. They appeared to consider


more external factors such as absence of organisational roles and patient-family influences on nurses' decision-making to reason such sub-optimal levels of practice. Positive changes and fulfilment of those external factors are fundamental prerequisites for improving the quality of care and patient outcomes in cancer pain management.

However, as a nurse involved in research, I learned that 'knowing about something does not always lead to doing something with that knowledge', unless we realised and seriously considered that the consequences of our decisions could have significant impact on us as well. I started thinking that looking for causes of the unmet quality of care from the external factors, with minimum reflections on how and what we as nurses contributed to the issues. To rationalise that there was nothing much nurses could do to make changes was easier than taking actions which seemed a greater personal and professional risk. However, nurses do need to take responsibility for pain management and show a level of commitment to patients. When I asked myself, if it was true that there was nothing these nurses could do to initiate and/or maintain positive changes to improve their practice, my answer was "Yes, there were something." What we could do at the outset could be something very small, but every little drop of our efforts underpinned by an intention for positive changes would lead to chances of achieving our aim for improving the quality of care and patient outcomes. Otherwise, there would be no chance, if we kept saying, "Well, there is nothing I can do."

As I discussed previously in this Chapter, the consequences of inadequate management of cancer pain does not only have negative impacts on patients and their families, but also on nurses. Therefore, improving the quality of nursing practice based on evidence is critical, and use of EBGs is an effective way of demonstrating EBP in managing cancer pain, although the process of adopting change in practice may require a lot of effort.

Within the current situations, as seen from this study, *nursing practice in the South Korean healthcare context, the workplace culture and the social expectations and attitudes towards nurses*, it may not be easy for nurses to initiate changes as envisaged within the study recommendations. Nurses need to realise that pain management is an integral and key part of their role. Individual nurses need to realise/recognise the issues in complex cancer care, and take on roles that actively involve them in pain care; they need to engage in self-development, assert themselves in care situations and express their concerns and views in relation to patient care and treatments. What we have taken for granted in our nursing practice in cancer pain management may not and/or should not be taken for granted. On reflection on what I saw and heard during my study journey, it is my belief that a paradigmatic shift needs to occur as outlined in the Table 5.2. below.

Table 5.2. *A Paradigmatic Shift in Korean Nurses' Approaches to Pain Management; Implications for Education and Practice (Modified from McMillan, 1985; Watson, 1982)*

| Reigning Paradigm |  Challenging Paradigm |
|---|--|
| Reliance on acquisition of knowledge | A focus on the discipline of nursing as a profession |
| Scientific Medico's knowledge base especially around drug therapy | Commitment to nursing knowledge and competence around pain management |
| Limited repertoire of nursing care activities | Future consideration of the potential for the expansion of the scope of practice to be influenced by the patient's needs, the care setting, nurse abilities and competence and Evidence-based policy |
| Disease orientation Curative Focus Nursing procedures and tasks | Nursing interventions responding health deficit and preventive care, coping with stress in illness, building resilience and sustaining the patient |
| Medical team hierarchy | Nursing team hierarchy/adherence to standards |
| Learn by doing | Multiple perspectives based on evidence |

| | |
|---|---|
| Procedural direction e.g. NGTB | Multiple perspectives based on evidence |
| Reliance on ritual and habit | Focus on questioning/problem-solving. Transfer of Learning. Knowledge-based decision-making |
| Implementation of a regime at the direction of medicos | Fully participate in Person-centred care directed by a nursing framework |
| Institutionalized care under supervision | Interdisciplinary, collaborative care strategies and processes |

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Appendices

Appendix 2.1. Review list of guidelines for cancer pain management

| | | MHW & NCC (5 th ed., 2013) | MHW & NCC (6 th ed., 2015) | CANO (2004) | CCNS (2005) | SIGN (2008) | NCCN (2017) | NHS (2009) | AACPMGWP (2016) |
|-----------------|---|--|--|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|
| | AGREE Score | Recommended | Strongly recommended | Strongly recommended | Strongly recommended | Strongly recommended | Strongly recommended | Strongly recommended | Strongly recommended |
| Recommendations | Assessment of pain | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| | Assessors of pain | No | No | Yes | Yes | Yes | Yes | Yes | Yes |
| | Timing/ frequency of assessment | Not clear | Not clear | No | Yes | Yes | Yes | No | Yes |
| | Components of pain assessment | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| | Assessment of pain in special populations | No | Yes | Yes | Yes | Yes | No | No | Yes |
| | Plan of care | No | Yes | Yes | Yes | No | Yes | No | No |
| | Pharmacological intervention | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| | Non-pharmacological intervention | Yes but without complementary therapy | List of NPI options without detailed description | Yes | Yes | Yes | Yes | Yes | Yes |
| | Documentation | No | No | Yes | Yes | No | No | No | Yes |
| | Education | No | Yes | No | Yes | Yes | Yes | Yes | Yes |
| | Outcome measures | No | No | No | No | No | Yes | No | No |

MHW & NCC, Ministry of Health and Welfare & National Cancer Centre; CANO, Canadian Association of Nursing Oncology; CCNS, Cancer Care Nova Scotia; SIGN, Scottish Intercollegiate Guidelines Network; NCCN, National Comprehensive Cancer Network ; NHS, National Health Service Quality Improvement Scotland; AACPMGWP, Australian Adult Cancer Pain Management Guideline Working Party

Appendix 2.2. Appraisal for cancer pain management related guidelines using AGREE II

| Guideline | Domains (%) | | | | | | Overall |
|--|-----------------|-------------------------|-----------------------|-------------------------|---------------|------------------------|----------------------|
| | Scope & Purpose | Stakeholder Involvement | Rigour of Development | Clarity of Presentation | Applicability | Editorial Independence | |
| MHW & NCC (5th ed), 2013 | 57.1 | 57.1 | 48.2 | 81 | 28.6 | 14.3 | Recommended |
| MHW & NCC (6th ed), 2015 | 66.7 | 71.4 | 69.6 | 81 | 42.9 | 14.3 | Strongly recommended |
| CANO, 2004 | 81 | 61.9 | 39.3 | 90.5 | 39.3 | 21.4 | Strongly recommended |
| CCNS, 2005 | 100 | 76.2 | 66.1 | 85.7 | 50 | 78.6 | Strongly recommended |
| SIGN, 2008 | 100 | 90.5 | 91.1 | 95.2 | 75 | 14.3 | Strongly recommended |
| NCCN, 2017 | 85.7 | 57.1 | 67.9 | 71.4 | 28.6 | 35.7 | Strongly recommended |
| NHSQIS, 2009 | 81 | 66.7 | 35.7 | 85.7 | 46.4 | 14.3 | Strongly recommended |
| ACPMGWP, 2016 | 81 | 76.2 | 71.4 | 90.5 | 57.1 | 92.9 | Strongly recommended |

Appendix 2.3. Summary of literature reviewed

| Title | Author, year | Participants/ MMAT score | Remarks |
|---|---------------------------|--|--|
| An Ethnographic Study of Barriers to Cancer Pain Management and Opioid Availability in India | LeBaron et al., 2014 | 59 RNs MMAT: 50 | <ul style="list-style-type: none"> - Examine barriers to opioid availability and cancer pain management in India, with an emphasis on the experiences of nurses - Purposive, snowball sampling strategy; in-depth, semi-structured interviews (n = 54), 400+ hours of participant observation, and review of documents over 9 months - Morphine is more available at this study site than in most of India, but access is limited to patients seen by the palliative care service, and significant gaps in supply still occur. Systems to measure and improve pain outcomes are largely absent. Key barriers related to pain management include the role of nursing, opioid misperceptions, bureaucratic hurdles, and sociocultural/infrastructure challenges. |
| Barriers to cancer pain management: Jordanian nurses' perspectives. | Al Khalaileh et al., 2012 | 96 RNs (150 survey distributed) MMAT: 50 | <ul style="list-style-type: none"> - To explore barriers to cancer pain management among Jordanian nurses. - Convenience sample from 3 hospitals; an Arabic translation of Ward and colleagues' barriers questionnaire II. - The nurses expressed high levels of barriers on the questionnaire, with a mean score of 2.5 for the questionnaire as a whole (standard deviation (SD) 0.8). The harmful and physiological effects of medications subscales received the highest mean scores (RNs may have a strong belief in the effect of pain meds). (misbelief); No significant difference between experiences of having education and score |
| Levels of Barriers to Pain Management of Cancer Patients and their Nurses | Yoo, 2005 | 155 Pts; 153 RNs MMAT: 50 | <ul style="list-style-type: none"> - to provide basic data for developing an effective strategy for cancer pain management by comparing the levels of barriers to pain management of metastatic or advanced cancer patients and their nurses. - a tool developed by Gunnarsdottir et al. (2002) - Higher levels of barriers to pain management were found in three groups: 'less than middle school education background,' 'not treated with anti-cancer chemotherapy,' and 'ECOG of 2.' The level (2.55) of barriers to pain management in the patient group was higher than that (1.76) of the nurse group. Both of the two groups had high levels of barriers in two variables: 'There is a danger of becoming addicted to pain medicine.' and 'Using pain medicine blocks your ability to know if you have any new pain.' There was not a significant difference in the levels of stresses between the two groups |
| Pain intensity, pain control and pain control barriers between cancer patients and their nurses | Byun & Choi, 2013 | 90 cancer Pts; 90 oncology nursing record MMAT: 100 | <ul style="list-style-type: none"> - descriptive study - to compare the levels of pain intensity and pain relief between cancer patients and nursing records and to compare the barriers to pain control between cancer patients and their nurses - The most severe pain intensity (cancer patients: 6.59; nursing records was 3.98); Significant changes in pain intensity over time between two groups ($F=142.07$, $p<.001$); The highest level of pain relief (reported by patients: 2.87 on the third day; nursing records: 1.67 on the first day); Perception gap between Pt and RNs |
| Attitudes, beliefs, and practices of Sri Lankan nurses toward cancer pain management: An ethnographic study | De Silva & Rolls, 2011 | 10 RNs MMAT: 100 | <ul style="list-style-type: none"> - To explore the experiences and cancer pain management practices of nurses working at a government hospital in Sri Lanka. - Participant observation, semi-structured interviews and maintaining a research diary. - Sri Lankan nurses perform poor cancer pain management practices due to a lack of resources, a shortage of nurses, and poor workload allocation within the hospital. Additionally, the nurses are not autonomous, and are required to refer to medical staff for cancer pain management strategies. The nurses work in a task-oriented system that rarely acknowledges cancer patients' pain management needs. |

| Title | Author, year | Participants/ MMAT score | Remarks |
|--|----------------------|---|---|
| Oncology nurses' perception of cancer pain: a qualitative exploratory study | Garcia et al., 2015 | 5 RNs MMAT: 75 | <ul style="list-style-type: none"> - To explore how oncology nurses perceive cancer pain in patients for whom they provide care. - Semi-structured interviews - The findings offer insight into how nurses themselves respond to under-treatment of cancer pain. Responses such as frustration, helplessness and emotional distress were reported. Identification of shortfalls in training and education, lack of comprehensive assessment of pain, and deficits in pharmacological and non-pharmacological treatment of pain. |
| Nurse moral distress and cancer pain management: an ethnography of oncology nurses in India. | LeBaron et al., 2014 | 37 RNs; 22 other healthcare providers MMAT: 75 | <ul style="list-style-type: none"> - To explore the experience of moral distress with oncology nurses and other providers in India and its potential relationship to opioid availability. - Primary themes included "We feel bad," "We are alone and afraid," "We are helpless," and "We leave it." A weak link between MD and opioid availability was found. - Conclusions: Participants described significant work-related distress, but the moral dimension to this distress was less clear as some key aspects of the Integrated Model of Nurse Moral Distress were not supported. The concept of MD may have limited applicability in settings where alternative courses of action are unknown, or not feasible, and where differing social and cultural norms influence moral sensitivity. |
| Knowledge of cancer pain management for clinical nurses | Park, 2013 | 267 RNs MMAT: 50 | <ul style="list-style-type: none"> - Descriptive study - To provide basic data in the development of cancer pain management program for clinical nurses by evaluating their knowledge about pain management - Mean score for cancer pain management knowledge (20.53); pain assessment (2.99), pain management in different age group (2.23), use of pharmacological interventions (10.74), nursing care for patient with pain (4.13) and placebo (0.4); Significant influential factors: age, educational background, position, length of service, educational experience and frequency of education |
| Factors affecting nurse's pain management for cancer patients | Song & Kim, 2010 | 229 RNs MMAT: 100 | <ul style="list-style-type: none"> - Descriptive study - To examine potential factors related to the management of cancer pain, that is, hospital institutional factors as well as personal aspects of nurses. - nurses' knowledge about pain intervention, their working division and their knowledge about the use of analgesics had different effects on their pharmacologic interventions; nurses' knowledge about pain interventions and nursing organization were variables affecting non-pharmacologic interventions by the nurses; suggested for placement of nurse practitioners, improvement of nurses' autonomy in pain management, and development and distribution of standardized guidelines |
| Knowledge about cancer pain management of clinical nurses | Kim, 2008 | 303 RNs MMAT : 50 | <ul style="list-style-type: none"> - 77% return rate from 3 university hospitals; the instrument (Nurses' knowledge and attitudes survey regarding pain' (Ferry, McCaffery, 2006)) - to measure knowledge of cancer pain management of clinical nurses - Mean score of knowledge about cancer pain management (20.4/40); Low score in the groups (younger than 25 years old, college graduated, RNs in emergency department and 1-2 years of working experience; significantly higher score in the group with experience of cancer pain management education |

| Title | Author, year | Participants/ MMAT score | Remarks |
|--|---------------------|--|--|
| Knowledge and awareness of nurses and doctors regarding cancer pain management in a tertiary hospital | Kim, 2012 | 725 RNs; 95 MOs MMAT: 100 | <ul style="list-style-type: none"> - Cross sectional study - to compare and check the levels of cancer pain management knowledge and awareness between doctors and nurses in a tertiary hospital and to develop an intervention program. to identify if the CPMG has changed cancer pain management practice among RNs and MOs - In a comparison of the pain management score, nurses showed significant results for age ($p < .001$), carrier ($p < .001$), education ($p < .001$), working area ($p < .001$), and doctors showed significant results only for age ($p = .032$). Doctors' marks were significantly higher than nurses' in pain management scores ($p < .001$). Knowledge about analgesic medication ($t = -5.38$, $p < .001$) and analgesic drug effect ($t = -8.59$, $p < .001$) were significantly different in the pain management subcategory score between nurses and doctors. There were four items with different awareness levels related to analgesics between nurses and doctors. |
| Knowledge and attitudes of nurses in veterans hospitals about pain management in patients with cancer | McMillan, 2000 | 85 nurses (RNs and LPNs) MMAT: 50 | <ul style="list-style-type: none"> - To assess nurses' knowledge and attitudes about pain management and patients in pain. - Exploratory, descriptive. - Areas of major knowledge deficits included physiology of pain and pharmacology of analgesics; Nurses were most knowledgeable about the importance of asking patients about their pain, around-the-clock scheduling, tolerance, and use of distraction. Patient behavior, age, and gender seemed to unduly influence nurses in their pain management decisions. Regarding attitudes about pain management, the majority of nurses did not agree that patients and their families should have the most control over analgesic scheduling and that a constant level of analgesic should be maintained in the blood. In fact, 82% indicated that around-the-clock analgesics increase the risk for sedation and respiratory depression. |
| A comparative study on the knowledge and attitude of cancer pain management between nurses working in general units and cancer units | Kwon, 2009 | 125 oncology RNs; 137 general RNs MMAT: 75 | <ul style="list-style-type: none"> - Descriptive study - To compare and recognise the levels of cancer pain management knowledge and attitude of RNs - Significantly higher knowledge among RNs in cancer wards, esp. in knowledge about analgesic administration and its actions - Significantly higher attitudes among RNs in cancer wards |
| Hospice and hospital oncology unit nurses: a comparative survey of knowledge and attitudes about cancer pain. | Hollen et al., 2000 | 30 hospice and 34 oncology nurses MMAT: 50 | <ul style="list-style-type: none"> - To identify knowledge strengths and weaknesses and misperceptions about cancer pain management between two groups of RNs in different settings. - Descriptive, comparative survey. - The North Carolina Cancer Pain Initiative survey and a demographic survey - Hospice nurses scored significantly higher than hospital oncology unit nurses regarding overall pain management knowledge, opioids, scheduling, and liberalness. Hospice nurses also reported more pain education and a higher frequency of pain guideline review requirements than hospital oncology unit nurses. |

| Title | Author, year | Participants/ MMAT score | Remarks |
|--|-----------------------|------------------------------------|--|
| A survey about nurses' knowledge and attitudes of cancer pain management | Nam, 2003 | 300 RNs (analysed 273) MMAT: 50 | <ul style="list-style-type: none"> - Descriptive survey - To exam clinical nurses' knowledge and attitudes towards cancer pain management and suggest basic information for ongoing education - Average rate of correct response : knowledge about cancer pain management (63.63%); about general pain (77.95%); about cancer pain (89.60%); about analgesics (70.50%); about pain scale (43.57%); about pain intervention (64.41%); most positive attitude: needs of monitoring adverse effects when patients were on opioid analgesics (98.5%); Negative attitude: administering opioid analgesics; Pain education experience influenced on all sub- categories of knowledge (general, cancer pain, analgesics, pain scale and interventions) |
| A study of oncology nurse's knowledge, attitudes and intervention methods regarding cancer pain management | Park, 2012 | 209 RNs MMAT: 50 | <ul style="list-style-type: none"> - Descriptive study - To provide fundamental data needed for effective management of cancer pain by investigating knowledge, attitudes and intervention of oncology nurses regarding cancer pain - Correct answer rate about cancer pain (70.9%); Pain management education experience (81.8%); average number of education 3.67 times; Relatively positive attitudes (Mean=1.57; SD=0.64); Pharmacological intervention- frequently used: morphine (81.3%); oxycodone (71.3%) and fentanyl (68.9%); Adverse effects of pharmacological interventions: vomiting (71.3%), constipation (64.1%), sedation and drowsiness (55.5%), and dizziness (53.1%); Use of non-pharmacological interventions: hot bag (42.6%), providing information/education (20.1%) and ice bag (18.8%) |
| A university hospital nurses' knowledge and attitude about cancer pain management | Kim & park, 2012 | 303 RNs MMAT: 50 | <ul style="list-style-type: none"> - Descriptive survey study - An inventory questionnaires consisting with 107 questions - To investigate a hospital nurses' knowledge and attitude about cancer pain management to use the outcomes as basic data for education - the percentage of correct answers for general knowledge about pain (79.6%); knowledge about cancer pain (82.2%); knowledge about analgesics use (55.6%); attitude towards pain management (65.2%); and the percentage of correct answers for each item was 70.7%; The knowledge about analgesics use was significant difference in age, education level, position, years of nursing practice, present place of working, years of present working place, pain education program experience; the attitude about pain management was significant difference in gender, education level and present place of working |
| Knowledge and attitudes of Turkish oncology nurses about cancer pain management | Yildirim et al., 2008 | 68 oncology RNs MMAT: 50 | <ul style="list-style-type: none"> - To examine the knowledge and attitudes of Turkish oncology nurses regarding cancer pain management. - Employed in oncology and hematology units in two university hospitals; The Nurses' Knowledge and Attitudes Survey Regarding Pain - The average correct response rate (35.41%); the mean number of correctly answered questions (13.81 ± 5.02); nurses' background characteristics, the nurses' pain knowledge was only positively correlated to length of working experience in oncology units (r = 0.263; p < .05) The findings support the concern of inadequate knowledge and attitudes in relation to cancer pain management. |
| Knowledge level and attitudes of nurses toward cancer pain management | Kim, 2004 | 320 RNs MMAT: 75 | <ul style="list-style-type: none"> - Descriptive survey - To investigate the knowledge about and attitudes towards cancer pain management - Average correct response: general knowledge of pain (65.0%), cancer pain (64.5%), use of analgesics (49.2%), pain scale (26.8%) and interventions (42.1%); 58.5% RNs were not hesitate to administer opioid analgesics; use of PRN analgesics on first report of pain (40.1%) and second report (38.8%); Pain management education: significant influential factor, but 61.5% RNs had no pain management education experience, high request rate for needs of education |

| Title | Author, year | Participants/ MMAT score | Remarks |
|---|-------------------------|---|---|
| Quantitative study of oncology nurses' knowledge and attitudes towards pain management in Saudi Arabian hospitals | Alqahtani & Jones, 2015 | 320 RNs MMAT: 75 | <ul style="list-style-type: none"> - Cross-sectional survey - Examine RNs' knowledge and attitudes regarding pain management in Saudi Arabian hospitals - Relatively poor overall knowledge and attitudes of pain management (significant variation to the RN's nationality, attendance of pain related courses and research participation) |
| Knowledge and attitudes about cancer pain management: a national survey of Italian oncology nurses | Bernardi et al., 2007 | 287 RNs MMAT: 50 | <ul style="list-style-type: none"> - Descriptive survey - To obtain information about the knowledge and attitudes of Italian oncology nurses concerning cancer pain management and to determine the predictors of nurses' pain management knowledge - Mean number of correctly answered question: 21.4 (6-35); More than 50% of oncology RNs: underestimated the patients' pain (inadequately treat it); an incorrect self-evaluation about their pain management knowledge; RNs with higher mean correct answer scores: attended more pain education courses, but still presented with significant knowledge deficits & erroneous beliefs that may hamper treatment pain |
| The clinical nurses' knowledge and practice on nursing intervention to relieve the pain of patients with cancer | Hwang, 2006 | 210 RNs MMAT: 50 | <ul style="list-style-type: none"> - Descriptive survey - Instrument developed by Watt-Watson & Donovan (1992) and revised by Hyun (1999) - To investigate the clinical nurses' knowledge and practice on nursing intervention to relieve the pain in patients with cancer - Correct responses: general knowledge for pain (68.8%), knowledge for cancer patients' pain (84.4%) and knowledge for direction of an analgesics (55.3%); Significant difference depending on: length of cancer care experience, nursing unit characteristics and educational experience of pain; Well-known and frequently used pain scales: numerical scale and simple descriptive scale and most useful scale: numerical scale; Frequently suggested pain intervention: administering PRN analgesics, applying cold & hot therapy and providing information |
| Hospice ward and medical ward nurses' knowledge and performance of cancer pain management | Yu, 2011 | 50 RNs from hospice wards, 53 RNs from a medical ward MMAT: 50 | <ul style="list-style-type: none"> - Descriptive comparative study - To understand knowledge and performance of cancer pain management of nurses - RNs in hospice wards were older, had higher educational background, longer and richer healthcare experience. RNs in hospice wards who completed a pain management training and were aware of the existence of the CPMG had higher knowledge and better performance; Mean score for knowledge: RNs in hospice wards were significantly higher than medical ward; RNs in hospice wards had better cancer pain management performance; Statistically positive correlation between knowledge and performance |
| Knowledge and performance of nurses' cancer pain management | Mun, 2014 | 140 RNs MMAT: 50 | <ul style="list-style-type: none"> - To find out nurses' particular personal characteristics, their cancer pain management knowledge, their performance of cancer pain management and to determine the relationship between these - Knowledge of cancer pain management (72.35%); Performance of cancer pain (4.08 +/- 0.93 on 5 Likert scale); Difference in knowledge: personal characteristics (marital status as single, work experience- greater than 10 years' experience, working area- hospice care); RNs with palliative care experience and being aware of existence of the CPMG had significantly higher score; Difference in performance: personal characteristics (marital status - single, work experience- hospice and haematology oncology); RNs with cancer care experience, palliative care experience and being aware of existence of the CPMG had significantly higher score - Positive corelationship between knowledge and performance |

| Title | Author, year | Participants/ MMAT score | Remarks |
|--|--------------------|--|--|
| Nurses' knowledge and level of performance of pain management of cancer patients | Jang, 2015 | 330 RNs MMAT: 75 | <ul style="list-style-type: none"> - Descriptive correlational study - To compare knowledge and level of performance in dealing with cancer pain management - The average score of knowledge of the subjects was 19.21 ± 6.16 out of 30 points; there was a significant correlation between the subjects' knowledge and level of performance ($r=0.488$, $p<.001$) |
| Nurses' knowledge and performance of cancer pain management | Cho, 2009 | 364 RNs MMAT: 50 | <ul style="list-style-type: none"> - Descriptive study - to understand the knowledge and performance of cancer pain management in clinical nurses based on the CPMG (2008) - Total mean score of the knowledge of cancer pain management (74.5%); Total mean score of the performance for cancer pain management (3.03); Significant differences in knowledge and performance (age, total length of service, field of service, position, educational background, religion, marital status, pain management education experience, number of pain management education, length of cancer care, awareness for the CPMG); significant positive relationship between knowledge about and performance for cancer pain management |
| The comparison of nurses' and doctors' knowledge and performance toward cancer pain management | Kim, 2014 | 45 MOs and 99 RNs MMAT: 50 | <ul style="list-style-type: none"> - Descriptive study - To identify current status of performance and knowledge about cancer pain management among MOs and RNs - CPMG based questionnaire - MOs had more knowledge about cancer pain management, esp. internal medicine Drs.; Length of working 5-15 yrs (RN) and 2 or 3 yrs (MO): higher score of knowledge; No significant difference: post-graduate level; RNs: significantly low score in using analgesics; No significant difference between RNs and MOs in cancer pain management performance - RNs in the wards had better performance than the ones in special areas; Completion of pain education: significantly influence on performance |
| Evidence-Based Practice Beliefs and Behaviors of Nurses Providing Cancer Pain Management: A Mixed-Methods Approach. | Eaton et al., 2015 | 40 RNs for web-based surveys; 12 RNs for Interviews MMAT: 66.6 | <ul style="list-style-type: none"> - Descriptive, cross-sectional with a mixed methods approach - To describe EBP beliefs and behaviours of RNs who provide cancer pain management - RNs agreed with the positive aspects of EBP and their implementation ability, but low implementation level; RNs were satisfied with their pain management practices; Oncology nursing certification: associated with innovativeness, innovativeness: associated with EBP beliefs; Themes: limited definition of EBP; varied evidence-based pain management decision making; limited identification of evidence-based pain management practice; integration of non-pharmacological interventions into patient care |
| Using a mixed methods approach to explore factors associated with evidence-based cancer pain management practice among nurses. | Eaton et al., 2017 | 106 RNs for questionnaire; 12 total RNs, 2 NUMs, 3 CNSs, 1NE, 2 CNOs for interview MMAT: 66.6 | <ul style="list-style-type: none"> - Descriptive, cross-sectional with a mixed methods approach - To answer the following questions: (a) What nurse-level and organizational-level factors are associated with evidence-based cancer pain management practices? (b) What is the organization's EBP environment, and barriers to and strategies for adopting evidence-based cancer pain management practices among nurses? - Organizational-level factors are associated with nursing documentation of evidence-based cancer pain management practice; Hospitals need an infrastructure and resources to facilitate adoption and implementation of evidence-based pain management; APRNs, Pain Resource Nurses, and Magnet designation may positively facilitate EBPM adoption and implementation among nurses |

Appendix 3.1. Standard attributes of innovation (Greenhalgh et al., 2008; Healthcare Improvement Scotland, 2013b)

| Attributes | Description |
|---------------------------|--|
| Relative advantage | That they are considered unambiguous and an advantage in terms of either effectiveness or cost-effectiveness |
| Compatibility | Compatible with the values, norms and perceived needs of intended adopters |
| Complexity | Easy to use |
| Triability | Possibility of experiment on a trial basis |
| Observability | Observable benefits of an innovation |
| Reinvention | Able to reinvent the innovation for intended adopter's own needs |

Appendix 3.2. Aspects of adopters and the adoption process (Greenhalgh et al., 2008)

| Aspects | Descriptions |
|---|---|
| General psychological antecedents | Personality traits such as intellectual ability, motivation, values and learning style have link with tendency of adopting innovations |
| Context | Specific psychological antecedents- Intended adopters' motivation and ability to use the innovation, agreement with personal needs and behavioural congruence with the intended adopter's identity promote adoption of the innovation |
| Meaning | Congruence of meaning from the innovation and the intended adopter enhance adoption of the innovation |
| Nature of the adoption decision | Decision to adopt the innovation is commonly dependent to other decision (contingent, collective and authoritative) and this have influence on initial adoption and its successful implementation |
| Concerns in the pre-adoption stage | Sufficient information regarding the innovation itself and its potential influence on individual are important prerequisites |

Appendix 3.3. Vision, strategies and core values of the study setting

| | |
|--------------------|---|
| Vision | <ul style="list-style-type: none"> - The hospital to present the best cure experience - The hospital to lead the world 'Medical science for women's health' - The hospital to create the coexistence model in the medical world - The hospital to promote the quality of community health - The hospital where outstanding personnel want to work with |
| Strategies | <ul style="list-style-type: none"> - Specialisation - Advance of Operation - Value-up Branding - Expansion |
| Core Values | <ul style="list-style-type: none"> - Loyalty - Intimacy - Fairness - Excellence |

Appendix 3.4. Demographic characteristics of RNs

| RN's Name (Initial) | Jina | Eunsoo | Jinhee | Eunah | Younhee | Miho | Jeongmi | Kyoungmi | Nari | Youngsook |
|-----------------------------------|------|--------|--------|-------|---------|------|---------|----------|------|-----------|
| Gender | F | F | F | F | F | F | F | F | F | F |
| Age (year) | ~30 | ~30 | ~30 | ~40 | ~30 | ~30 | ~30 | ~35 | ~30 | ~30 |
| Length of working as a RN (year) | ~5 | ~10 | ~10 | ~20 | ~10 | ~10 | ~10 | ~5 | ~10 | ~10 |
| Length of cancer care (year) | ~5 | ~10 | ~10 | ~15 | ~10 | ~10 | ~10 | ~5 | ~10 | ~10 |
| Employment status | FT | FT | FT | FT | FT | FT | FT | FT | FT | FT |
| Education status | B | D | D | MP | D | D | MP | D | D | D |
| Cancer pain management experience | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| Awareness of the CPMG | N | N | N | N | Y | N | N | N | Y | N |

F: Female; FT: Full time/ PT: Part time; D (Diploma)/ B (Bachelor)/ MP (Master- in progress) Y: Yes/ N: No

Appendix 3. 5. Details and contents of education

| RN | Details of Education | | | | | Contents of the education | | | | | | | | | Notes |
|-----------|----------------------|------------|----------|---------|------------|---------------------------|---------|------------|----------|---------|------------|----------|-----|------|-----------------|
| | Type | Time | Provider | Lengths | Frequency | Pathophysiology of pain | Pain Ax | Analgesics | W & C Tx | Massage | Relaxation | Music Tx | PMG | TAPM | |
| Jina | In-service | 6 mths ago | Work | 1-2 hrs | once | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | |
| Eunsoo | In-service | This yr | Work | 2hrs | N/A | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | inc. NRS, FLACC |
| Jinhee | In-service | 1 year ago | Work | 1hr | once | ✓ | ✓ | ✓ | | ✓ | ✓ | | | | inc. Ax tools |
| Eunah | In-service | 1 year ago | Work | 1hr | once | ✓ | ✓ | ✓ | | | ✓ | | | | inc. Ax tools |
| Younhee | Hospice education | 1 yr ago | Work | 6hrs | every year | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | inc. Ax tools |
| | Cancer pt Mx. | 2yr ago | KNA | 5days | every year | | | | | | | | | | |
| Miho | In-service | 2yrs ago | Work | 2hrs | once | ✓ | ✓ | ✓ | | | | | | | inc. Ax tools |
| Jeongmi | In-service | 2 mths ago | Work | 1hr | once | | ✓ | ✓ | | | | | ✓ | ✓ | inc. Ax tools |
| Kyoungmi | In-service | 6 mths ago | Work | 2hrs | once | ✓ | ✓ | ✓ | | ✓ | ✓ | | | | inc. Ax tools |
| Nari | In-service | 9 mths ago | Work | 1hr | once/ 2yr | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | inc. Ax tools |
| Youngsook | In-service | 2yrs ago | Work | 2hrs | once | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | inc. Ax tools |

Ax. (Assessment); FLACC (Face Legs Arms Cry Consolability Scale); hr (hour); inc. (including); lx (Interventions); KNA (Korean Nurses' Association); mth (month); Mx. (Management); N/A (Not available);

NRS (Numeric Rating Scale); PMG (Pain Management Guideline); pt (Patient); TAPM (Team approach for pain management); W & C Tx (Warm & Cold therapy); yr (year)

Appendix 3.6. Information letter

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An Exploratory Study of Cancer Pain Management by Nurses in South Korea

Document Version [IS-2013-1-1]; dated [/ /]

You are invited to participate in the research project described above, which is being conducted by Miran Kim who is undertaking research studies for a PhD under the supervision of Professor Isabel Higgins, Dr Sarah Jeong and Professor Margaret McMillan from the School of Nursing and Midwifery at the University of Newcastle in Australia.

Why is the research being done?

The aims of the research are to

- explore the experiences of nurses with the management of people with cancer pain,
- identify the facilitative factors and/ or barriers involved in current cancer pain management practice in Korea and
- determine the extent to which the practice of Korean nurses is consistent with current evidence based guidelines for cancer pain management.

Who can participate in the research?

For this study, we are seeking registered nurses

- who have more than three years of experience caring for adult people with cancer
- who are permanently employed on the study unit
- who are **directly** involved in care of cancer patients with pain
- who are **indirectly** (eg. manager level) involved in care of cancer patients with pain
- who have not experienced recent personal loss or recovered from the loss

What choice do you have?

Participation in this research is entirely your choice. Only those people who give their informed consent will be included in the project. Whether or not you decide to participate, your decision will not disadvantage you.

If you decide to participate, you may withdraw from the project at any time without giving a reason and you have the option of withdrawing any data which identifies you.

What would you be asked to do?

If you agree to participate, you will be asked to:

- Be observed by the student researcher for period of 6 to 9 months whilst you provide care for patients with cancer who give consent to the student researcher being present during care. Observations and reflections by the student researcher will be recorded in a field note diary/ journal. And/Or
- Participate in an interview with the student researcher for up to one hour regarding your experiences of managing pain in people with cancer and allow the student researcher to audiorecord the interview for transcription and analysis later. Interviews will occur when is convenient for the participant in a private area nominated by the participant.

How Much time will it take?

- The observation periods will take place while you are on duty and caring for people with cancer. Observation periods may last up to a maximum 8hours or the duration of one working shift
- Interviews will take approximately an hour.

What are the risks and benefits of participating?

Because this study does not involve any interventions or any changes in the routine care of patients with cancer, it is not expected to cause any harm to the patients or the nurses in the setting. However, given that participants provide nursing care to the patients with cancer and/or pain in where death can occur; potential participants may experience emotional distress during the interviews. Potential participants who may feel uncomfortable discussing issues related to death, dying, cancer and/or pain and who have unresolved issues with grief will be advised not to participate in this study. However, if any unexpected issues of risk or harm such as cardiac arrest and fall are detected or foreseen during the study, the student researcher will stop the process of the study immediately. The student researcher will take an appropriate level of action such as commencing cardio-pulmonary resuscitation and seek the intervention of appropriate healthcare professionals as per the policy and/or protocol of the setting. The student researcher will report to both DON (and/or NUM) and the supervisors and make further decision based on agreement and the boundary of ethics.

Also, the student researcher may detect potentially harmful practices, which are expected to lead serious harm or death to anyone in the field. In a situation like this, the researcher will need to negotiate at the outset of the study an agreed position with the Director of Nursing on an adequate route for discussion of any major queries about study participants or patterns of care.

Participation in the study, and/or non-participant nurses, health care professionals, and patients and their families may feel uncomfortable about the student researcher's presence and being observed. They might ask the researcher to leave the scene; the student researcher will then ceases

observations and leave the scene. The student researcher will make sure that there is no imminent health problem and if requested refer the participant to the appropriate resources available to support them.

There are no direct benefits to participants; however, it is believed that participation in interviews can be therapeutic as they will be able to reflect on their practice in cancer pain management. It is hoped that future nurses and patients benefit from new knowledge that this study will generate.

How will your privacy be protected?

- If you agree to participate interview and observation data will be kept confidential with the researchers.
- Pseudonyms or will be used in transcriptions of the interviews, in the field note diary and any of reports emerging from the study including the production of a thesis.
- Interview will be conducted in a private area nominated by the participant.
- The hard copies of information, field notes, tapes, interview transcripts and personal journal will be locked in a filing cabinet in my office until the end of the study, and the data will be only used for this study.
- All electronic files containing the data from the study will be password protected and a regular backup will be made and stored in a secured location in my office.
- Once the study is completed all data will be archived for five years as per the policy of the University of Newcastle, and only the researcher and the supervisors can access the files to maintain the issues of privacy and confidentiality.
- After five years of archiving, all electronic data will be erased, the tapes destroyed and paper based records shredded.

How will the information collected be used?

- The results will be reported in peer reviewed journal articles. Also, the finding of the study will be presented in a thesis to be submitted for Ms Miran Kim's degree of Doctor of Philosophy.
- You will be given a choice to receive at least a summary of the study in plain language. Please, indicate your wish in consent form.

What do you need to do to participate?

Please read this Information Statement and be sure you understand its contents before you consent to participate. If there is anything you do not understand, or you have questions, contact Ms Miran Kim.

If you would like to participate, please sign the attached consent form and return it to Ms Miran Kim in the reply paid envelope provided. The researcher will contact you to arrange a time convenient to you for the observation or the interview following receipt of the consent form.

Further information

If you would like further information please contact Miran Kim on 070 [REDACTED] or Miran.Kim@uon.edu.au.

Thank you for considering this invitation.

Miran Kim (Research Student)
School of Nursing & Midwifery
Faculty of Health
The University of Newcastle

Complaints about this research

This project has been approved by the University's Human Research Ethics Committee, Approval No. H- 2012 - 0071. Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, if an independent person is preferred, to the Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2308, Australia, telephone (02) 49216333, email Human-Ethics@newcastle.edu.au.

연구참여를 원하는 간호사들을 위한 정보지

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국내 간호사들의 암성통증관리에 대한 조사연구

Document Version [IS-2013-1-1]; dated [/ /]

여러분은 위에 서술된 것과 같이 Isabel Higgins 교수님과 Sarah Jeong 교수님, Margaret McMillan 교수님의 감독하에 호주의 뉴캐슬 대학교, 간호대학에서 박사학위 과정 중인 김미란의 연구 프로젝트에 초대되었습니다.

본 연구는 왜 시행하나요?

본 연구의 목적은

- 암성통증 관리에 대한 간호사들의 경험을 조사하기 위함입니다.
- 국내 암성통증 관리 실무의 촉진 요소와 장애 요소를 밝히기 위함입니다.
- 한국 간호사들의 임상실무가 최근의 근거중심 암성 통증 관리 지침서를 따르고 있는지 보기 위함입니다.

누가 본 연구에 참여할 수 있나요?

본 연구를 위해서 다음의 간호사를 찾고 있습니다.

- 3년 이상의 성인 암환자 간호 경력을 가지고 있는 간호사; 그리고
- 연구 대상 병동에 영구적으로 고용된 간호사; 그리고
- 암성 통증을 가지고 있는 암환자의 간호에 **직접적**으로 연관된 간호사; 또는
- 암성 통증을 가지고 있는 암환자의 간호에 **간접적** (예. 관리자 수준)으로 연관된 간호사
- 최근 개인적인 상실을 경험하지 않았거나 상실을 회복한 간호사

연구 참여자들의 선택권은?

본 연구에 대한 참여 여부는 전적으로 여러분의 선택에 달려있으며, 오직 동의서를 작성하여 주신 간호사들만 본 연구에 참여하게 됩니다. 본 연구에 참여하거나 참여하지 않겠다는 여러분의 선택은 여러분에게 어떤 불이익도 주지 않을 것입니다.

만일 본 연구에 참여하기로 결정하셨어도, 여러분은 본 연구가 진행되는 중 타당한 이유를 제시하지 않고도 언제든지 연구에서 빠질 수 있으며, 여러분의 개인 신상이 드러날 수 있다고 여겨지는 어떤 정보도 제외시키실 수 있습니다.

연구 참여자들은 무엇을 하게 되나요?

만일 본 연구에 참여하기로 의하신다면:

- 6-9 개월 간 간호사의 참관에 대해 동의한 양환자들에게 여러분이 간호를 제공하는 동안 연구학생이 **관찰** 할 수 있도록 허락합니다. 연구학생에 의한 관찰과 반영은 현장 기록 노트/저널에 기록될 것입니다. 혹은
- 여러분의 양환자들에 대한 통증관리 경험에 관해 연구 학생과 한 시간 정도의 **면담**을 하게되며 추후 면담 내용의 전사와 분석을 위해 연구 학생이 녹취하는 것을 허락합니다. 면담은 참여자들이 편한 시간에 참여자들이 선택한 개별적인 장소에서 이루어집니다.
- 관찰, 그리고 면담 모두

시간은 얼마나 걸리나요?

- 관찰은 근무 중에 길게는 8 시간까지 혹은 근무가 이뤄지는 시간 동안 이루어지며
- 면담은 약 한 시간 정도 소요됩니다.

연구참여에 따른 위험이나 이익은 어떤 것들이 있나요?

본 연구는 암성 통증을 가지고 있는 환자 간호를 위해 이미 시행되고 있는 임상 실무나 일반적인 간호에 변화를 주는 수행을 적용하지 않기 때문에 연구가 이루어지는 병동의 환자들이나 간호사들에게 어떤 위험도 예상되지는 않습니다. 하지만, 연구의 참여자들이 양환자 간호(통증간호)를 제공하고 있고 암이 죽음과 연관성이 있으므로, 면담을 하는 동안 정서적 고통을 경험할 수도 있습니다. 죽음, 죽음의 순간, 암과 통증에 대해 토론함에 있어 불편감을 느끼거나 비탄감으로 인한 해결되지 않은 문제를 가지고 있는 예비 참여자들은 이 연구에 참여하지 않기를 권고합니다. 그러나, 만일 심장마비와 낙상과 같이 예측되지 않았던 위험이 본 연구동안 보여지거나 예측된다면 본 연구학생은 연구를 즉각 중단 하고 심폐소생술을 시작하고 연구 기관의 방침과 규약에 따라서 올바른 의료진의 중재를 구하는 등 적정수준의 행동을 취할 것입니다. 연구학생은 간호부장(수간호사)와 지도교수들에게 보고하고 합의와 윤리적 범위 안에서 추후 결정을 내리도록 할 것입니다.

또한, 연구학생은 임상에 있는 누구에게도 심각한 해나 죽음을 유발할 수 있는 잠정적으로 해로운 실무를 발견할 수도 있습니다. 이런 경우, 연구학생은 적절한 방법으로 간호 부장님과 사전에 이런 가능성들과 대응에 대한 협의를 할 것입니다. 본연구에 참여하는 간호사, 혹은 참여하지 않는 간호사와 타 의료 전문가들, 환자와 가족들이 연구학생이 관찰을 위해 실무 현장에 있음으로 인해 불편을 느끼고 연구자에게 그 자리를 피해 줄 것을 요구하는 경우, 연구학생은 즉시 관찰을 멈추고 그 자리를 떠날 것입니다. 본 연구학생은 본 연구로 인해 심각한 의료문제가 생기지 않도록 최선을 다할 것이며 만일 필요한 경우 참여자들이 도움을 받을 수 있는 적절한 지원을 의탁할 것입니다.

연구 참여로 인한 연구 참여자들의 직접적인 이익이 예상되는 것은 아니나, 면담을 하는 동안 암성 통증 관리에 대한 여러분 자신의 임상실무에 대해 반영해 볼 기회가 될것이므로 본 연구가 여러분에게 치료적 영향을 끼칠 것이라 봅니다. 본 연구를 통해 얻어진 새로운 지식이 장래에 간호사들과 환자들에게 도움이 되길 바랍니다.

연구 참여자의 프라이버시는 어떻게 보호되나요?

- 만일 여러분이 연구 참여에 동의하신다면, 면담과 관찰된 정보는 연구자들에 의해 기밀처리 됩니다.
- 면담의 전사와 현장 기록 노트, 최종 논문을 비롯한 연구에 의해 생겨난 모든 보고서에서는 가명이 사용됩니다.

- 면담은 참여자에 의해 선택된 개별 공간에서 시행됩니다.
- 출력된 정보와 현장 노트, 테이프, 면담 기록, 개인 저널은 연구가 끝날 때까지 본 연구 학생의 연구실에 있는 잠금장치가 되는 문서보관함에 보관 될 것이며, 오직 본 연구를 위해서만 사용될 것입니다.
- 모든 전자 파일은 비밀번호가 설치되어 보호되고 정기적인 백업이 시행될 것이며 본 연구자의 연구실 내 안전한 장소에 보관될 것입니다.
- 모든 연구가 완료된 이 후에는 모든 정보가 뉴캐슬 대학교의 방침에 따라 5 년간 보관되며, 프라이버시와 개인정보 보호를 목적으로 본 연구자와 지도 교수님들만 볼 수 있습니다.
- 5 년의 보관 기간이 끝나면, 모든 전자 데이터들은 삭제될 것이고 테이프는 파괴되며 지면서류들은 파쇄될 것입니다.

수집된 정보는 어떻게 사용되나요?

- 본 연구의 결과는 동료 평가를 시행하는 학술지에 등재될 것이며, 또한 김미란의 박사학위 논문에도 수록될 것입니다.
- 여러분은 본 연구의 결과에 대해 쉽게 쓰여진 요점정리를 제공 받을 수 있습니다. 원하신다면 연구 동의서 작성시 표시해 주십시오.

연구 참여를 위해 연구 참여자는 무엇을 해야 하나요?

참여에 동의하기 전에 본 정보 제공지를 잘 읽으시고 동의서의 내용을 숙지하십시오. 만일 내용 중에 이해되지 않는 것이 있거나 질문이 있다면 본 연구자에게 연락을 주십시오.

만일 본 연구에 참여하기를 원하신다면, 첨부된 동의서에 서명하시고 제공된 선불봉투에 넣어 본 연구자 (김미란)에게 보내주십시오. 본 연구자가 동의서를 받는데로 여러분의 관찰이나 면담에 있어 편리한 시간 결정을 위해 연락을 드릴 것입니다.

추후 정보

만일 자세한 정보가 필요하시면 본 연구자 (김미란)에게 전화 070 8283 ■■■ 혹은 이메일 Miran.Kim@uon.edu.au로 연락하십시오.

본 초대를 고려해주셔서 감사합니다.

김미란 (연구 학생)
뉴캐슬 대학교, 보건학부, 간호대학


본 연구에 대한 불만사항

본 연구는 뉴캐슬 대학 인간 연구 윤리 위원회 (the University's Human Research Ethics Committee)에 의해 허가된 연구 (허가번호: H-2012-0071)입니다. 본 연구의 참여자로서 권리를 가지고 있거나, 혹은 본 연구가 시행되는 방식에 대해 불만이 있는 경우, 본 연구자에게 말할 수 있고, 개별적인 연락을 원하는 경우 인간 연구 윤리 담당자 (주소: the Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2308, Australia, 전화: 61249216333, 이메일: Human-Ethics@newcastle.edu.au.)에게 연락할 수 있습니다.


Appendix 3.7. Recruitment poster

1. English version

An investigation of cancer pain management
by nurses in South Korea



I would like to talk with Nurses who are interested in participating in a study designed to explore cancer pain management practices of nurses.



You may wish to find out more about the study- 'Participant Information Letters' that will be given by your Nurse Unit Manager.

Or contact me, Miran Kim, doctoral student,
School of Nursing & Midwifery, University of
Newcastle, Australia
(or Full-time lecturer, School of Nursing,
[redacted] University)

Nursing Research

For further information on 0708283 [redacted] (Contact number in Korea)

2. Korean version

국내 간호사들의
암성통증관리에 대한 조사연구



암환자 간호 실무에서 간호사들의 암성통증 관리가 어떻게 시행되고 있는지 알기 위한 연구에 참여하기 원하시는 간호사 선생님들과 대화를 나누고 싶습니다.



연구와 관련하여 더 자세한 내용은
수간호사 선생님께서 나눠드릴
'참가자 정보지'를 참고하시거나,
호주 뉴캐슬대학교 간호대학에서
공부하고 있는 박사학위 학생인
저(김미란; [redacted] 간호과 전임강사)
에게 개별문의 하실 수 있습니다.

Nursing Research

자세한 내용은 전화 0708283 [redacted] (한국번호) 로 문의 해주세요.

Appendix 3.8. Consent form- Nurses

FACULTY OF HEALTH



THE UNIVERSITY OF
NEWCASTLE

AUSTRALIA

Research student

Miran Kim RN., BN., MN., PhD Candidate.

School of Nursing & Midwifery

University of Newcastle

Email: Miran.Kim@uon.edu.au

Tel: (+61 2) 422 132 [REDACTED]

070 8283 [REDACTED] (in Korea)

Supervisors

| | | |
|---|--|--|
| Prof Isabel Higgins Email: Isabel.Higgins@newcastle.edu.au Tel: (+61 2) 4921 [REDACTED] Fax: (+61 2) 4921 [REDACTED] | Dr Sarah Jeong Email: Sarah.Jeong@newcastle.edu.au Tel: (+61 2) 4349 [REDACTED] Fax: (+61 2) 4349 [REDACTED] | Prof Margaret McMillan Email: Margaret.McMillan@newcastle.edu.au Tel: (+61 2) 4349 [REDACTED] Fax: (+61 2) 4349 [REDACTED] |
|---|--|--|

Consent Form for the Research Project: An Investigation of Cancer Pain Management by Nurses in South Korea

Document Version [IS-2013-1-2]; dated [/ /]

I agree to participate in the above research project and give my consent freely.

I understand that the project will be conducted as described in the Information Statement, a copy of which I have retained.

I understand I can withdraw from the project at any time and do not have to give any reason for withdrawing.

I consent to

- participating in an interview and having it recorded; (Yes/No)
- the researcher to use what she observe my nursing practice regarding cancer pain management; (Yes/No)
- both interview and observation (Yes/No)

I understand that my personal information will remain confidential to the researchers. I have had the opportunity to have questions answered to my satisfaction.

Print Name

Signature

Date

Contact Details (H or M)

(Email)

I would like a summary of the findings of the research sent to me. (Please circle one): Yes/ No

Please return this form to Ms Miran Kim in the envelope provided to you. Please do not hesitate to call her on 010 4084 [REDACTED] / 070 8283 [REDACTED], if you have any concern. Thank you.

간호사의 암성 통증 관리와 관련된 인식 및 역할에 대한 조사연구: 비판적 문화기술지적 접근

| 연구책임자 | 연구담당자 | 공동연구자 | | |
|-----------------|----------------------------|---|--|--|
| 010- [REDACTED] | 김미란 010-4084-[REDACTED] | Isabel Higgins (+61 2) 4921 [REDACTED] | Sarah Jeong (+61 2) 4349 [REDACTED] | Margaret McMillan (+61 2) 4349 [REDACTED] |

※ 아래 동의서를 주의 깊게 읽고 각 항목에 정확히 ☒ 표시 해 주십시오.

1. 본인은 임상연구에 대해 구두로 설명을 받고 상기 피험자 설명문을 읽었으며 담당 연구자와 이에 대하여 의논하였습니다.
2. 본인은 위험과 이득에 관하여 들었으며 나의 질문에 만족할 만한 답변을 얻었습니다.
3. 본인은 이 연구에 참여하는 것에 대하여 자발적으로 동의합니다.
4. 본인은 이후의 치료에 영향을 받지 않고 언제든지 연구의 참여를 거부하거나 연구의 참여를 중도에 철회할 수 있고 이러한 결정이 나에게 어떠한 해가 되지 않을 것이라는 것을 알고 있습니다.
5. 본인은 이 설명문 및 동의서에 서명함으로써 의학 연구 목적으로 나의 개인정보가 현행 법률과 규정이 허용하는 범위 내에서 연구자가 수집하고 처리하는데 동의합니다.
6. 본인은 이 동의서 사본 1 부를 받을 것을 알고 있습니다.

본인은 위 사항에 대한 모든 설명 및 답변을 들었으며 충분한 이해를 바탕으로 자발적인 동의를 합니다. ☐

저는 다음에 동의 합니다. (원하는 항목에 ☒ 표시 요함)

- 면담참여, 면담내용 녹음, 면담내용의 연구활용 및 발표; ☐
- 암성 통증 관리와 관련된 간호실무에 대한 연구자의 관찰, 관찰내용의 연구활용 및 발표; ☐
- 면담과 관찰 모두, 면담 및 관찰내용의 연구활용, 발표 ☐

피험자

이 름 _____ 서 명 _____ 날 짜 _____

연락처 (집 혹은 휴대폰) _____ 이메일 _____

동의서를 설명한 사람 이름

_____ 서 명 _____ 날 짜 _____

연구 책임자 (공동연구자)

이 름 _____ 서 명 _____ 날 짜 _____

저는 연구 결과 요약본을 받아보기 원합니다. (원하는 곳에 ○표 해주세요); 예/아니오

본 동의서를 제공된 봉투에 넣어 밀봉 후 수거봉투에 넣어주세요. 만일 문의 사항이나 염려되는 점이 있으시면 010 4084 9501(김미란)로 전화주시기 바랍니다. 감사합니다.

Appendix 3.9. Information statement-Patient/family

FACULTY OF HEALTH



THE UNIVERSITY OF
NEWCASTLE
AUSTRALIA

Information Statement – Patient/Family

Research student

Miran Kim RN., BN., MN., PhD Candidate.
School of Nursing & Midwifery
University of Newcastle
Email: Miran.Kim@uon.edu.au
Tel: (+61) 422 132 [REDACTED]

Supervisors

Prof Isabel Higgins
Email:
Isabel.Higgins@newcastle.edu.au
Tel: (+61 2) 4921 [REDACTED]
Fax: (+61 2) 4921 [REDACTED]

Dr Sarah Jeong
Email:
Sarah.Jeong@newcastle.edu.au
Tel: (+61 2) 4349 [REDACTED]
Fax: (+61 2) 4349 [REDACTED]

Prof Margaret McMillan
Email:
Margaret.McMillan@newcastle.edu.au
Tel: (+61 2) 4349 [REDACTED]
Fax: (+61 2) 4349 [REDACTED]

An investigation of Cancer Pain Management by Nurses in South Korea

Dear Patients and Families of ward [XX]

My name is Miran Kim and I am a Registered Nurse. I am also a PhD student at the University of Newcastle, New South Wales, Australia. As a requirement of my studies, I am conducting a research project titled "An investigation of cancer pain management by nurses in South Korea".

Why is the research being done?

The purposes of the research are to

- explore the experiences of nurses with the management of people with cancer pain,
- identify the facilitative factors and/ or barriers involved in current cancer pain management practice in Korea and
- determine the extent to which the practice of Korean nurses is consistent with current evidence based guidelines for cancer pain management.

How does this research concern you?

Because this study is about how nurses care for people with pain I will be observing nurses during practice. Whilst patients and families are not the subject of this research, you are being asked to give permission for the student researcher to present, while a nurse is attending to your care. The student researcher will be observing the nurse interacting with you whilst providing your care. Because the nature of the study requires the researcher to observe the nurse providing care to patients this means that there may be several periods of observation conducted over several shifts. Each observation period is likely to be for eight hours. For each observation period the researcher will check with you and reaffirm your permission for the presence of the researcher. If you do not wish the researcher to be present during your care or should you have any concerns about the presence of the researcher in your personal space, please do not hesitate to let the nurse or the Nursing Unit Manager know about your concerns. Whether or not you provide permission for the researcher to be present during your care will not affect the care you are given by the nurse now or in the future. You have the right to refuse permission for the student researcher to be presented during your care to observe and this will not affect your care.

You will also notice the following sign placed within the ward.

Over the period between February, 2013 and December, 2013 a student researcher, Miran Kim will be present in this ward for the purpose of the research project. If you do not wish the student researcher to be present during your visit, please let the NUM or the nurses in the ward know, or ask the student researcher to leave the area. If you would like more information about the study, please contact the student researcher who will be happy to answer your questions.

Thank you very much.

Yours faithfully,

Miran Kim

Note. The university of Newcastle requires that all participants are informed that if they have any complaints concerning the manner in which a research is conducted it may be given to the researcher or if an independent person is preferred, to the Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2308, Australia, telephone (02) 49216333, email Human-Ethics@newcastle.edu.au (In Korean: [REDACTED], hy01157@gmail.com).

**간호사의 암성 통증 관리와 관련된 인식 및 역할에 대한 조사연구:
비판적 문화기술지적 접근**

문서 버전 [IS-2013-2-1]; 날짜 [/ /]

| 연구책임자 | 연구담당자 | 공동연구자 | | |
|------------------------------|----------------------------|---|--|--|
| 010- [REDACTED] - [REDACTED] | 김미란 010-4084-[REDACTED] | Isabel Higgins (+61 2) 4921 [REDACTED] | Sarah Jeong (+61 2) 4349 [REDACTED] | Margaret McMillan (+61 2) 4349 [REDACTED] |

() 병동에 계신 친애하는 환자 및 가족 여러분

안녕하십니까? 저는 간호사이면서 뉴캐슬 대학에서 박사학위를 하고 있는 김미란이라고 합니다. 제 학위의 일환으로 저는 “국내 간호사들의 암성통증관리에 대한 조사 연구”를 수행하고 있습니다.

본 연구는 왜 시행하나요?

본 연구의 목적은

- 암성통증 관리에 대한 간호사들의 경험을 조사하기 위함입니다.
- 국내 암성통증 관리 실무의 촉진 요소와 장애 요소를 밝히기 위함입니다.
- 한국 간호사들의 임상실무가 최근의 근거중심 암성 통증 관리 지침에 의해 이뤄지고 있는지 보기 위함입니다.

본 연구로 인해 염려스러운 점이 있으신가요?

본 연구는 간호사들이 통증이 있는 암환자를 어떻게 간호하는지를 보기위한 것이므로, 저는 임상실무를 수행 중인 간호사들을 관찰할 것입니다. 환자나 가족들은 본 연구의 대상이 아니므로 여러분을 담당하고 있는 간호사가 여러분에게 간호를 제공하고 있는 동안 그 간호의 내용들을 관찰할 수 있도록 동의해달라는 요구를 받으실 수 있습니다. 본 연구의 특성이 간호사가 환자들에게 제공하는 간호를 관찰하는 것이므로, 관찰은 필요에 따라 각기 다른 교대근무 시간 동안 수 차례에 걸쳐 이루어질 수 있습니다. 연구담당자는 관찰이 이루어지는 매 근무 시간 마다 연구담당자의 관찰에 대한 여러분의 동의를 재확인하고 허락받을 것입니다. 만일 간호사가 여러분에게 간호를 제공하는 동안 연구담당자가 와서 관찰하는 것을 원치 않으시거나, 연구담당자가 여러분의 개인적인 공간에 있는 것에 대해 염려스러운 점이나 불편한 점이 있으신 경우 담당 간호사나 수간호사에게 말씀해주시오. 간호사가 여러분에게 간호를 제공하는 동안 연구담당자가 관찰할 수 있도록 하는데 대한 여러분의 동의 여부는 여러분께서 제공받는 치료와 간호에는 아무런 영향을 끼치지 않을 것임을 알려드립니다.

여러분은 또한 병동 내에서 다음과 같은 알림문을 보시게 될 것입니다.

연구담당자 김미란은 2013년 5월에서 2013년 12월 까지의 기간 동안 연구의 목적으로 본 병동을 관찰 할 것입니다. 만일 여러분이 본 병동을 방문하는 동안 연구담당자가 여러분을 관찰하지 않기를 원하신다면 수간호사나 병동 간호사들에게 말씀하시거나 연구담당자에게 그 자리를 떠나줄 것을 요구할 수 있습니다. 만일 연구와 관련하여 더 자세한 정보가 필요하시면 연구담당자에게 질문해 주시면 기쁘게 답해드리겠습니다.

감사합니다.

김미란 드림

본 연구는 뉴캐슬 대학 인간 연구 윤리 위원회 (the University's Human Research Ethics Committee)에 의해 허가된 연구 (허가번호: H-2012-0071)입니다. 본 연구의 참여자로서 권리를 가지고 있거나, 혹은 본 연구가 시행되는 방식에 대해 불만이 있는 경우, 본 연구자에게 말할 수 있고, 개별적인 연락을 원하는 경우 인간 연구 윤리 담당자 (주소: the Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2308, Australia, 전화: 61249216333, 이메일: Human-Ethics@newcastle.edu.au.)에게 연락할 수 있습니다. 한국어로 문의를 원하시는 경우 [REDACTED] ([REDACTED]@gmail.com)으로 연락 주십시오. 또한 귀하는 연구 피험자로서의 귀하의 권리에 대해 의문이 있을 경우 [REDACTED] 병원 임상시험심사위원회(02-[REDACTED]-[REDACTED], [REDACTED])로 연락할 수 있습니다.

Appendix 3.10. Consent form- Patient/family

FACULTY OF HEALTH



Consent form –Patient/ Family

Research student

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Prof Margaret McMillan
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Fax: (+61 2) 4349 4538

Consent Form for the Research Project: An Investigation of Cancer Pain Management by Nurses in South Korea

I agree to be observed by the student researcher, whilst my nurse is providing care for me for the above research project and give my consent freely.

I understand that the project will be conducted as described in the Information Statement, a copy of which I have retained.

I understand I can refuse being observed at any time and do not have to give any reason for refusal.

I understand that my personal information will remain confidential to the researchers.
I have had the opportunity to have questions answered to my satisfaction.

Print Name: _____, Signature: _____

Date: _____

Please return this form to your nurse. Please do not hesitate to call her on 010 4084 9501/070 8283 9501, if you have any concern. Thank you.

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연구 프로젝트 동의서:
 국내간호사들의 암성통증관리 문화에 대한 조사 연구

김미란 (연구 학생)
 뉴캐슬 대학교, 보건학부, 간호대학

Professor Isabel Higgins (책임 지도교수)
 뉴캐슬 대학교, 보건학부, 간호대학

Dr Sarah Jeong (협력 지도교수)
 뉴캐슬 대학교, 보건학부, 간호대학

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 뉴캐슬 대학교, 보건학부, 간호대학

문서 버전 [01]; 날짜 [/ /]

저는 연구 학생이 연구를 위한 관찰을 위해 간호사가 간호를 제공하는 동안 참관하도록 제 뜻에 따라 동의서를 작성합니다.

이 름: _____

서 명: _____

날 짜: _____

연락처 (집 혹은 휴대폰) _____

(이메일) _____

간호연구 관련 알림문

연구담당자 김미란은 [REDACTED]
 윤리의원회에서 승인한 기간 (~ 2013 년 12 월)
 동안 연구의 목적으로 본 병동을 관찰 할
 것입니다. 만일 여러분이 본 병동을 방문하는
 동안 관찰 받기를 원치 않으시는 경우 연구학생
 본인이나 수간호사에게 말씀하실 수 있습니다.
 만일 연구와 관련하여 더 자세한 정보가
 필요하시면 연구학생에게 질문해 주시면
 친절하게 답해드리겠습니다.

자세한 내용은 전화 010 4084 [REDACTED] (김미란)로 문의 해주세요.

Appendix 3.12. Socio-demographic questionnaire

FACULTY OF HEALTH



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Australia +61 2 [redacted]
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An investigation of cancer pain management by nurses in South Korea

1. What is your gender?

| | |
|-----|-------|
| Mal | Femal |
| | |

2. How old are you?

| | | | | | | | |
|-----|-----|-----|-----|-----|-----|-----|-----|
| ~25 | ~30 | ~35 | ~40 | ~45 | ~50 | ~55 | 56~ |
| | | | | | | | |

3. How long have you been working as a registered nurse?

| | | | | | |
|-------|-------|-------|-------|-----|-------|
| ~ 5yr | ~10yr | ~15yr | ~20yr | ~25 | ~30yr |
| | | | | | |

4. How long have you been working in cancer care as a registered nurse?

| | | | | | |
|-------|-------|-------|-------|-----|-------|
| ~ 5yr | ~10yr | ~15yr | ~20yr | ~25 | ~30yr |
| | | | | | |

5. What is your employment status?

| | |
|------|------|
| Full | Part |
| | |

6. What is your education status?

| | | | | | |
|---------|----------|---------------------|-------------------|------------------|----------------|
| Diploma | Bachelor | Master- In progress | Master- Completed | PhD- In progress | PhD- Completed |
| | | | | | |

7. Have you attended education programs or in-service relating to pain management or pain management specific to people with cancer pain? (If yes, answer the following questions)

| | |
|-----|----|
| Yes | No |
| | |

7.1. Could you specify the details of all the education that you have, please?

| Type of education (eg. Inservice, Workshop, Postgraduate course etc) | Time of education (1 month ago etc) | Place of education (eg. Uni, work etc) | Length of education (eg. Days, Months etc) | Frequency of education (eg. Once, Monthly etc) |
|--|--|---|---|--|
| | | | | |
| | | | | |
| | | | | |

7.2. Please indicate all contents covered in the education.

| Pathophysiology of pain | Pain assessment (inc. tools) | Pain interventions | Pain management guideline | Team approach | Others |
|-------------------------|------------------------------|---|---------------------------|---------------|--------|
| | | Analgesics <input type="checkbox"/> Warm/cold therapy <input type="checkbox"/> Massage <input type="checkbox"/> Relaxation <input type="checkbox"/> Music therapy <input type="checkbox"/> Others <input type="checkbox"/> | | | |

7.3. Are you aware of the national guideline, the Cancer Pain Management Guideline?

| Yes | No |
|-----|----|
| | |

국내 간호사들의 암성통증관리에 대한 조사 연구

1. 성별

| | |
|---|---|
| 남 | 여 |
| | |

2. 연령

| | | | | | | | |
|-----|-----|-----|-----|-----|-----|-----|-----|
| ~25 | ~30 | ~35 | ~40 | ~45 | ~50 | ~55 | 56~ |
| | | | | | | | |

3. 총 근무 경력이 얼마나 되십니까?

| | | | | | |
|-------|-------|-------|-------|-------|-------|
| ~ 5yr | ~10yr | ~15yr | ~20yr | ~25yr | ~30yr |
| | | | | | |

4. 암 환자를 간호한 경력이 얼마나 되십니까?

| | | | | | |
|-------|-------|-------|-------|-------|-------|
| ~ 5yr | ~10yr | ~15yr | ~20yr | ~25yr | ~30yr |
| | | | | | |

5. 귀하의 고용상태는 무엇입니까?

| | |
|-----|------|
| 상근직 | 비상근직 |
| | |

6. 귀하의 최종 학력은 무엇입니까?

| | | | | | |
|------|----|-------|-------|-------|-------|
| 전문학사 | 학사 | 석사- 중 | 석사- 졸 | 박사- 중 | 박사- 졸 |
| | | | | | |

7. 통증 혹은 암성 통증관리에 대한 교육에 참여한 경험이 있습니까? (예의 경우 아래의 질문들에 답하세요)

| | |
|---|-----|
| 예 | 아니오 |
| | |

7.1. 교육의 종류와 기간, 빈도를 적어주세요.

| 교육의 종류 (예. 보수교육, 워크숍, 대학원 과정 등) | 교육 시기 (예. 한달 전 등) | 교육 장소 (예. 대학, 직장 등) | 교육 기간 (예. 시간, 일, 개월 등) | 교육 빈도 (예. 일회성, 매달 등) |
|---------------------------------------|----------------------|------------------------|---------------------------|-------------------------|
| | | | | |
| | | | | |
| | | | | |

7.2. 통증관리교육에 포함되었던 내용을 모두 표시해주세요.

| 통증발생기전 | 통증사정 (측정도구포함) | 통증중재방법 | 통증관리 기관지침 | 통증관리 팀 접근법 | 기타 |
|--------|------------------|--|--------------|---------------|----|
| | | 진통제사용□ 냉온요법□ 마사지□ 이완요법□ 음악요법□ 기타□ | | | |

7.3 암성통증관리 권고 지침서에 대해 알고 있으신가요?

| | |
|---|-----|
| 예 | 아니오 |
| | |

Appendix 3. 13. Interview schedule

| Topics | Sub-questions | Comments |
|--------------------|---|----------|
| Nurse's experience | Could you please describe your experiences in relation to cancer pain management. 암성통증 관리와 관련된 경험을 얘기해주세요. | |
| | Could you please tell me about an ordinary cancer care period with regarding pain and pain treatment, describing a patient you have been responsible for, before and after any treatment and or procedure? 담당했던 암환자 중 일반적인 간호기간 동안 치료나 시술을 받기 전과 후의 통증과 통증 치료 경험에 대해 말씀해 주세요. | |
| | What do you think the most important role as a nurse in cancer ward? 암병동에서 일하는 간호사로서 선생님의 가장 중요한 역할은 무엇이라고 생각하십니까? | |
| | What about pain? Is pain management important for you to take care of cancer patients? Why? 통증관리는 어떻습니까? 암환자들을 간호하는데 통증간호가 중요하다고 생각하십니까? 왜 그렇게 생각하십니까? | |
| Assessment | Could you please describe what you interpret as signs of pain (how you interpret pain) in patients with cancer. 환자가 통증이 있다는 것을 어떻게 압니까? 어떤 증상을 보고 암환자들이 통증을 가지고 있다고 생각하게 됩니까? | |
| | How do you usually assess the patient's cancer pain? 암환자의 통증을 어떻게 사정하십니까? | |
| | In which situations do you find out if the patient is in pain? 어떤 상황에서 환자가 통증이 있는지를 알게됩니까? | |
| | What do you think influences the assessment of pain? 통증을 사정할 때 어떤 것들에 영향을 받습니까? | |
| Treatment | Describe what influences your decision about how to treat pain in patient with cancer. 선생님께서 암환자들의 통증을 어떻게 치료/관리할 것인지 결정을 해야 할 때 영향을 주는 것들은 어떤 것들이 있는지 말씀해 주십시오. | |
| | What actions do you perform to alleviate pain? 간호사로서 통증을 완화시키기 위해 무엇을 하십니까? | |
| | Do you know of any treatment that you do not use to alleviate pain? Why not? 알고는 있지만 사용하지 않는 통증 완화 방법이 있습니까? 왜 사용하지 않습니까? | |
| | Could you please describe your experiences of the weaknesses and strengths of different methods for treating pain in cancer patients. 암환자들의 통증을 치료하기 위해 사용하고 있는 방법 중 각각의 방법들의 장점과 단점에 대한 선생님의 경험을 얘기해주세요. | |
| | Could you please describe what you experience as difficult with assessing and treating pain in cancer patients. 암환자들의 통증을 사정하고 치료함에 있어 경험했던 어려움에 대해 얘기해주세요. | |
| | Are there any circumstances that make optimal pain alleviation difficult? 효과적인 통증완화를 하는데 있어 어려운 점들은 무엇입니까? | |
| | Could you please describe your experiences of alternative treatments to pharmacologic treatments when treating pain in cancer patients. 암환자들의 통증을 치료할 때 사용하는 약물요법 이외의 다른 방법들에 대한 경험을 얘기해주세요. | |
| | How do you evaluate the effect of pain treatment? 통증완화 간호수행에 대한 평가를 어떻게 하십니까? | |
| Evaluation | Could you please describe your experiences of patients who do not become pain free after your intervention of the pain. 통증완화를 위한 간호를 제공한 후에도 완화되지 않는 통증을 가지고 있는 환자들에 대한 경험을 얘기해주세요. | |
| | How do you evaluate the effect of pain treatment? 통증완화 간호수행에 대한 평가를 어떻게 하십니까? | |
| Factors | Are there any facilitators for cancer pain management? What are they? How are they? 암통증 관리를 촉진시키는 방법들에는 무엇이 있을까요? 어떻게 촉진시킵니까? | |
| | Are there any barriers for cancer pain management? What are they? How are they? 암통증 관리를 어렵게하는 요소들은 무엇이 있을까요? 어떻게 방해합니까? | |

Appendix 3.14. Sample reflective journal

| | | | | |
|----------|---|--|------------------------|---|
| 14 30 | <p>약 15분 간의 Teabreak를 마치고 온 KHJ 간호사는 오전에 근무했던 간호사에게서 오후에 자신이 담당해야 할 15명 (total 18 beds for her today)의 환자들에 대해 인계를 받는다. 인계는 각 환자에 대한 요약된 기록이 들어있는 인계장과 필요에 따라서 EMR의 내용을 같이 보며 이루어졌다. KHJ 간호사는 필요에 따라서 중요한 내용, 주로 근무 중 자신이 꼭 챙겨서 해야 하는 부분들과 다음 근무자에게 인계를 해주어야 하는 내용들을 인계장과 A4용지 반 쪽이 되는 종이 한 장에 자신의 필요에 따라 구분을 하며 메모를 하고 표기를 한다. 오전 근무 동안에는 통증을 호소하여 문제가 됐던 환자가 없었다. (Was this verbally handed over? Is it a routine practice to handover patients with pain and how pain was controlled?) 그녀가 오늘 오후에 담당하게 될 15명의 환자들 중 2명은 퇴원 계산을 마치면 오후에 퇴원을 할 것이고 이 두 명의 환자들이 퇴원을 하면 총 5개의 빈 침대를 갖게 된다.</p> | <p>RN Jina received handover from the morning RN for her 15 patients (she had 18 beds in total for the shift), once she finished about 15 minutes tea-break. Basically, the morning nurse used worksheets (one page per patient, which contain patient's name and number, diagnosed issues, name of consultant and registrar, medications including intravenous fluid and oral medication, lab data, care plan including any following test and procedure and some reminding points such as pain assessment time) to deliver handover and if they need more detail they also looked for more information in EMR. RN Jina had memo re: important issues that she had to resolve during her duty and things that she had to pass onto the night RN on the worksheet that morning, afternoon and night RNs used and a little piece of paper as well. She sometimes separated contents that she wrote on the worksheet from her own paper. The morning RN didn't mention about any patient who complained pain in the morning. Later I asked Jina if there was no patient with pain issue this morning. She answered me if there was one the morning RN would mentioned, but because the morning RN didn't say any, she would guess there was none. Two of her 15 patients already had paid for their admission and treatment fees, so once they had their discharge medications. Once, these two were discharged RN Jina would have 5 empty beds.</p> | Nurses' station | High Nr-Pt ratio |
| | | | Handover | Handover- disease and medical approach focused. |
| | | | Worksheets & Memos | Worksheet: brief summary of each Pt. it is renewed daily. Worksheets for common handover and memo for her personal note for important thing to remember. Worksheets & Memos- Tools to avoid making mistakes, but remind tasks that Nrs completed |
| | | | Handover | No active questioning re: pain. Most questions were related to the tasks she had to solve or pass onto the RN for night shift |
| | | | 5 empty beds | Potential for increased unpredictable workload, which may cause pressure on her. |

Appendix 3.15. Audit trail of the analysis process

Appendix 3.15.1. Sample transcription of interview data (Korean-English)

| | | |
|--------|---|--|
| 000741 | <p>미란: 혹시 지금까지 돌봤던 환자 중에 특별하게 생각이 나는 환자가 있어요? 뭐 통증 때문에 이런 어떤 에피소드를 가지고 있는 이런 환자..?</p> <p>경미: 어.. 에피소드를 가지고 있는 환자? 생각나는 환자 분.. 처음 타이레놀부터 시작해서 통증 조절 했다가 나중에는 데메롤 IV 까지 갔던 환자 분이 있거든요? 암성 통증 조절이 안 되가지고.. 그런 환자 분들.. 통증 때문에 고생했던 분은 그 분 생각 나요..</p> <p>미란: 그 환자는 무슨 cancer 었어요?</p> <p>경미: 그 분이.. pancreatic ca 였나? 뭐였더라? 췌장암과.. ovary ca 와 여러가지 복합성 암이 정말 전신 meta 가 돼있는 상태였어 가지고, 음.. 저희한테는 흔한 케이스는 아니였거든요. 근데 췌장암 자체가 워낙 pain 호소가 심한 암이여 가지고, 조절하면서 계속 보는데도 조절이 안 되가지고 되게 힘들어 하셨었던 케이스..</p> | <p>Miran: Well, are there any patients particularly you remember still? The patients who had any pain related episodes?</p> <p>Kyoungmi: Uh... a patient with an episode... a patient that I remember... There was a patient who initially started with Tylenol to manage pain and she went on to use Demerol IV at the end... Because her pain wasn't controlled. [I remember] such patient, I remember that patient [when I recall my memory of such patient] who had difficult time because of pain.</p> <p>Mira: What kind of cancer she had?</p> <p>Kyoungmi: She was... [Did she have] pancreatic ca. [cancer]? What was she? I think she had pancreatic cancer and ovary cancer. [She had] few different types of cancer with whole body metastasis... umm... for us, she wasn't a common case. Anyhow, because pancreatic cancer causes too much pain, we had a difficult time, because her pain wasn't controlled despite the [pharmacological] interventions.</p> |
| | <p>미란: 그러면 이 환자는 오셔가지고 여기에서 어떠 어떠한 치료를 받았어요?</p> <p>경미: 우선은 항암.. 수술을 하셨구요. 저희한테 수술하신 거 아니고, 다른 병동에서 수술하고 내려오셨어요. 항암을 시작을 하셨는데, 항암을 하면서도 구토도 있었고, 거기다 이제 통증까지 있는데다가 항암이 잘 안 들었던 케이스였었거든요~ 그니까 암은 계속 전이가 되고 이런 상태니까 통증은 계속 진행되는 거고.. 저희도 해드린다고 이제 진통제랑 이런 걸 계속 해드리는데 듣진 않고.. 그랬던 케이스..</p> | <p>Miran: Then what kind of treatment she had?</p> <p>Kyoungmi: First of all, she had chemo... surgery done. She didn't have her surgery with us [not while she was on the ward], but she came to us after she had her surgery in another ward. [Then] she started having chemotherapy, and she had vomiting while she had chemotherapy. Also, she had pain and her chemotherapy didn't work well. I mean, her cancer was continuously spreading, thus the pain was progressed, and although we were providing analgesic and other medications, the pain wasn't subsided well.</p> |
| | <p>미란: 그렇게 했을 때 선생님의 느낌은 어땠어요?</p> <p>경미: 어~ 속상하죠.. 좀.. 좀 뭔가 해드리고 싶은데 해드릴 수 있는 거에는 선이 있고, 그리고 또 그때 뭐였지? ...옆에서 보기에 참 안타깝죠.. 내가 뭔가 해줄 수 있는 게 있으면 해드리고 싶은데, 해드릴 수 있는 거는 권한에 몇 가지 제한이 있잖아요? 뭐 약을 저희가 처방해서 드릴 수 있는 것도 아니고, 그런 뭐.. hot pack.. 그리고 좀 쓰다듬어 드리고 뭐 이런 정도? 그리고 손 잡고 얘기해드리고, 그리고 다른 거 좀 하시라고.. 재밌는 거리 이런 거 해드리고, 뭐 앞에 환자분들하고 얘기하시라고 대화를 좀 이끌어 드리고.. 뭐 이런 정도? 하는 거 외에는..</p> | <p>Miran: How did you feel about it, when things went in that way?</p> <p>Kyoungmi: Uh... It upsets me. I wanted to do something more, but there was limitation what I could do for her. // It was so sad... If there was anything that I could do, I wanted to do, but there are limitations in my right to give [interventions]. I mean we couldn't prescribe the medication, so all we could do were giving hot pack and giving rub a little bit... and holding her hands and talking with her... And [we encouraged] to do other things... encouraged her to do funny things and have chat with the patients in next beds. Something like this...</p> |

Appendix 3.15.2. Process of coding and developing themes

| Excerpt | Process | Generating initial codes | Searching for themes | Reviewing themes | Defining and naming themes |
|---|---------|--|--|--|---|
| (TL 11/ J-I-2)) Anyhow, pharmacological intervention is used the most , I think... Umm... [we] provide it a lot . [And also] make the position comfortable... [but] the most used is anyhow medicine. Particularly, I think we give out medicines a lot when patients complain [of pain], because they want it . | | Pharmacological intervention is the primary means of managing pain - Pharmacological intervention is used the most... - We give our medicines a lot when patients complain of pain... | Use of pharmacological interventions- primary | Making decision to use pharmacological interventions, because patients want it. | T2.3. Making decision about pain management 2.3.1. Reliance on pharmacological interventions |
| Participant nurses stated that pharmacological options were the primary interventions that nurses used to manage pain. As it was seen as very important to maximise the effectiveness of the interventions, using all available options based on evidence can be considered critical to optimal care and comfort. However, it appeared that the nurses used specific drug focused interventions in many cases rather than a comprehensive suite of interventions. | | | | | |
| (TM/ A-I-2) If the pain is not controlled with regular med , there would be prescription for short-acting [opioid] analgesic as a PRN with maximum dose. If there is such order, we go and get the meds and give it to the patient every time [patients complain of pain] . | | Pharmacological intervention is the primary means of managing pain - Use of both regular and PRN analgesics. | Use of pharmacological interventions- frequency (regular/PRN) | Making decision to use pharmacological interventions (PRN) when regular analgesic is not working. | T2.3. Making decision about pain management 2.3.1. Reliance on pharmacological interventions |
| Non-opioid analgesics and/or opioid analgesics were in use either regularly or PRN. | | | | | |
| (TC20/ A-VII-2) It would be good, if we could get [the opioid analgesia] right away, but because someone needs to go and get it [from the pharmacy, it takes time] . If an Assistant Nurse go and get it, it would take about 10 to 15minutes minimum, because she needs to go down to get it... If it was a bit closer or there is a pharmacy on the ward, there would be no need for concept | | Pharmacological intervention- primary means, but drug handling policy can block adequate pain management. - physical distance of the pharmacy; unable to take immediate action, hence concept of 'Prep' | Use of pharmacological interventions- alternative method, 'Prep' | Making decision to use pharmacological interventions (Prep) for breakthrough pain. RNs will alter their practice, when there is any barrier, but unable to guarantee its safety. | T2.3. Making decision about pain management 2.3.1. Reliance on pharmacological interventions |

| Process | Generating initial codes | Searching for themes | Reviewing themes | Defining and naming themes |
|---|---|---|---|---|
| <p>Excerpt</p> <p>of prep. Even without PRN or prep, we could go and get [opioid analgesia] right away, but because it's not possible and there is limitation to manage [opioid analgesia] on the ward, we do it like this. It's a bit like a trick...</p> | | | | |
| <p>Despite the active use of different analgesics, there seemed to be some difficulty in immediate obtaining those opioid analgesics. Given there was only one hospital pharmacy in the basement, patients with unexpected pain would not receive an immediate intervention, although a pharmacological approach was the primary intervention in the setting.</p> | | | | |
| <p>(TL 63/ A-VIII-1)</p> <p>... some volunteers coming to provide foot massage for those patients who have been referred for hospice care. They [patients] say they like it very much. On the day.... the day when the volunteers have visited, I can see different facial expression and the patients look absolutely comfortable. In a situation like this, I think doing massage and having chat [with the patient] could be much better in managing pain than giving medicine.</p> | <p>Use of non-pharmacological interventions could improve pain</p> <p>- Evidence of use of certain non-pharmacological interventions and it enhances comfort level.</p> | <p>Use of non-pharmacological interventions: reported their effectiveness by RNs, but performed by volunteers not by RNs.</p> | <p>Making decision to allied with volunteers in providing certain non-pharmacological interventions</p> | <p>T2.3. Making decision about pain management</p> <p>2.3.2. Non-pharmacological interventions: Limited use</p> |
| <p>There were some cases when the participant nurses witnessed the effectiveness of non-pharmacological interventions.</p> | | | | |
| <p>(TM 11/ F-I-2)</p> <p>I just give them pharmacological interventions and plus [sometimes use some non-pharmacological interventions]... For example, I've applied a hot pack, when a patient complained for abdominal pain, but I haven't done it a lot... Otherwise, well, I do say "Relaxation therapy... take deep breathing", but I don't just do it [non-pharmacological interventions] alone.</p> | <p>Use of pharmacological & Non-pharmacological interventions together</p> <p>- Use of both pharmacological and non-pharmacological interventions, but more pharmacological</p> | <p>Use of non-pharmacological interventions with pharmacological interventions, not alone.</p> | <p>Making decision to use non-pharmacological interventions, but limited use</p> | <p>T2.3. Making decision about pain management</p> <p>2.3.2. Non-pharmacological interventions: Limited use</p> |
| <p>Although there appeared to be some evidence of preference for their use, non-pharmacological interventions often seemed to be recognised as less valuable interventions among the participant nurses.</p> | | | | |

| Process | Generating initial codes | Searching for themes | Reviewing themes | Defining and naming themes |
|---|---|---|---|---|
| Excerpt (TC 25/ A-VII-17) ... we've learnt it [NPIs] quite bit as a nursing student and you can learn as much as you want to, if you are willing to. I don't think it's really difficult, but because I don't have enough time | Because I don't have enough time... - Know how to, but unable to perform due to time limit. | Time limitation for performing non-pharmacological interventions | Why RNs decide not to use non-pharmacological interventions: time limit | T2.3. Making decision about pain management 2.3.3. Influential factors on decision-making 2.3.3.1. Excessive workload limiting quality nursing care |
| Jina reflected on her thoughts on providing non-pharmacological interventions. Unlike the initial response regarding these, about which she did not seem to be confident, she stated that she learned about non-pharmacological interventions at some level as a nursing student and it would be possible for her to use them, if she wanted to. She said it would not be too hard for her to use them, but she did not have enough time to sit at the bedside to do this. She reported excessive workload that limited chances of offering quality nursing care | | | | |
| (TL 33/ D-IX-4) ... because they haven't been [scientifically] proven [of its effectiveness] yet, I can't competently recommend non-pharmacological interventions, ... because pharmacological interventions have been proved and you can see their effect, pharmacological interventions are used as the first choice. Because you can see the effect and your body reacts right away, and I think it is objective. Non-pharmacological interventions like massage, hot pack and things like that are not objective [scientific] | Pharmacological interventions have been scientifically proven, but NPIs are not objective - I can't competently recommend non-pharmacological interventions, because they haven't been proven... | RNs' assumption re: pharmacological & non-pharmacological interventions | Making decisions not to use non-pharmacological interventions, because considering it as not scientific | T2.3. Making decision about pain management 2.3.3. Influential factors on decision-making 2.3.3.2. Nurses' attitudes and assumptions |
| The participants appeared to consider pharmacological interventions were scientifically proven; hence, they were superior to non-pharmacological interventions. | | | | |

Appendix 3.15.3. Critical Incident Technique

| Categorising | Jina A-III-1 | Issues | Ways to resolve issues | | |
|------------------------------|---|--|---|---|--|
| pain occurrence | <p>... we[I] still have this patient on our[my] ward... <u>Uh this patient had a chemotherapy and now complains of pain due to its side effect</u>. But, the pain that this patient is complaining is not bone pain or anything like it. He is suffering from pain in the whole skin, so it is almost terrified him even with a little touch. He would be screaming with a brief grazing. The unknown origin pain was continued for 2~3days, but you couldn't find anything wrong in his skin with your eyes. But, he suffered from this pain and 2~3 days later.... <u>Now, his skin is peeled off</u>. So, the skin on his sole has been peeled off like some kind of sliced bit... Like this...</p> <p>Now, doctors from PS [Plastic Surgery] and our ward jump into him to do dressing... I remember the pain he feels, because it is the most recent happening... umm... Now, that patient with skin [problem]... I even can't touch him. I can't hold his hands, because it causes pain even with slight touch... For him, even when he moves his bowel, it is hard to clean him up. He even couldn't turn his body on the other side, because he was really obesity, so I even couldn't touch him. His skin was just like the one with burn... really... although we infused Morphine [mixed fluid] continuously, it couldn't stop [the pain]. Ah, well see although I wasn't a doctor, I really wanted to give him something to sedate him, so we could do whatever we had to do without him feeling pain. But, he wasn't in any condition that he could tolerate any interventions... Well, there is no way [to help him]... No verbal sedation! If I tried to encourage him to talk, it would cause him headache, he would have felt his brain was shaking... Of course no massage [was possible], no way for that... Turn the music on? For him? That was just really, really... really, really... it was really too crucial... I thought it was just too crucial for him [if I had to try any interventions on him]. // Sometimes I go into the room to help dressing, because it can't be done by one person. It breaks my heart, because the skin is like that [the skin is changed as if it has</p> | pain post-chemotherapy | A case of uncontrollable pain experience : Healthcare professionals including RN seem to be giving up on managing pain (or unable to facing it) because the pain is not controlled with even opioid analgesic. They rather seem to focus on managing skin which was on high risk of infection. They seem to accept pt's pain as inescapable part of the disease & treatment process. But it eventually seems to cause feeling of powerlessness and frustration | | <p>- Comprehensive assessment before intuitive assumption</p> <p>- Education: cancer pain management related; critical thinking skill, use of evidence, waken RNs for the value of their own practice</p> <p>- Hospice care involvement</p> <p>- Interdisciplinary team approach</p> |
| Description of pain | | - Pain in the whole skin - suffering, terrifying - unable to touch/hold his hands | | | |
| RN's frustration | | unable to find reason, but witnessing suffering | ? lack of knowledge | - Education including potential adverse reaction of Chemo-drug: able to link with pain occurrence | |
| Involvement of doctors | | attending dressing-more for infection prevention according to the outcomes of consultation | RN's frustration and powerlessness d/t unable to provide interventions; seems that she could go out of her scope of practice | - Specialised personnel involvement | |
| Pharmacological intervention | | infusion of Morphine mixed fluid | Use of analgesics including opioid analgesics, but doesn't appear to be adequate + RN hesitating to use some NPIs, because pt wouldn't be able to tolerate it | - interdisciplinary team approach-care conference (improving communication) | |
| Potential risk | | idea of practicing out of scope | Limited use of interventions | ? indication for other procedural interventions; | |
| RN's attitude | Assumption- no intervention Pt could tolerate | How RN know the Pt couldn't tolerate other interventions without comprehensive assessment | Needs of comprehensive assessment, even involvement of hospice team | | |

| | | | | |
|------------------|--|--|--|--|
| RN's frustration | <u>burn</u>]. Well, because the dressing like his couldn't be done with general dressing, <u>we had to have a consultation first and the dressing was done based on the answer of the consultation</u> . Now, we do irrigation. Like this, [we do] <u>irrigation with betadine, apply some ointment and apply burn gauze and bandage tightly</u> . Initially <u>we applied</u> | feeling of hopelessness | Use a lot of negative words (can't touch; can't hold; wasn't a doctor; no way; really too crucial; can't do...)= expression of frustration, helplessness, hopelessness, but is it true that there was no way...??? | Need of value of own practice, cooperation with MOs and other RNs through active communication |
| RN's attitude | <u>Teramycine ointment</u> , because it was covered with clusters throughout whole body. And now, now... <u>we are still applying Teramycin ointment, and it [what we use for dressing] keeps changing</u> . Because the patient's [condition] is changed daily, like he becomes not well and he is in a great pain, when we remove the dressing, <u>we apply Vaseline gauze or Vaseline ointment as daily</u> ... Aslo, <u>it became too much for us and had high risk of infection, we passed it onto the registrar and the PS [plastic surgery] doctors</u> ... so sometimes they do it or sometimes the residents or the interns do it. // See, <u>we're using analgesics as much as we can with increasing doses and we use opioid alangesics</u> ... | Care focused on prevention for infection, but no reflective further intervention for pain management | ? Acute management of disease focused care | Consideration of quality of life for Pt/ quality of care/ Pt outcomes |
| Potential risk | really you can see his pain with your eyes, <u>there is no way that he can't be in pain</u> . Really, his pain must cause suffering, [but] <u>you can't do anything for him</u> verbally or anything [non-verbally], really. Well, saying "You will be alright", it doesn't make sense. <u>You even can't look at him, you just do whatever you have to [and leave]</u> . <u>There is nothing that you can do</u> ... | Limiting engagement with the Pt to reduce the frustration/ professional conflict | | |

Appendix 3.16. Ethics approval- HREC

HUMAN RESEARCH ETHICS COMMITTEE



Notification of Expedited Approval

| | |
|--|---|
| To Chief Investigator or Project Supervisor: | Professor Isabel Higgins |
| Cc Co-investigators / Research Students: | Doctor Sarah Jeong Conjoint Professor Margaret McMillan Ms Miran Kim |
| Re Protocol: | An investigation of cancer pain management practice by nurses in South Korea |
| Date: | 12-Feb-2013 |
| Reference No: | H-2012-0071 |
| Date of Initial Approval: | 12-Feb-2013 |

Thank you for your **Response to Conditional Approval (minor amendments)** submission to the Human Research Ethics Committee (HREC) seeking approval in relation to the above protocol.

Your submission was considered under **Expedited** review by the Ethics Administrator.

I am pleased to advise that the decision on your submission is **Approved** effective **12-Feb-2013**.

In approving this protocol, the Human Research Ethics Committee (HREC) is of the opinion that the project complies with the provisions contained in the National Statement on Ethical Conduct in Human Research, 2007, and the requirements within this University relating to human research.

Approval will remain valid subject to the submission, and satisfactory assessment, of annual progress reports. *If the approval of an External HREC has been "noted" the approval period is as determined by that HREC.*

The full Committee will be asked to ratify this decision at its next scheduled meeting. A formal *Certificate of Approval* will be available upon request. Your approval number is **H-2012-0071**.

If the research requires the use of an Information Statement, ensure this number is inserted at the relevant point in the Complaints paragraph prior to distribution to potential participants You may then proceed with the research.

*****Please note and action the following:**

Now that the English version documents have been approved, please submit verified Korean translations of the participant documentation (eg, Information, Consent, Notice).

Conditions of Approval

This approval has been granted subject to you complying with the requirements for *Monitoring of Progress, Reporting of Adverse Events, and Variations to the Approved Protocol* as detailed below.

PLEASE NOTE:

In the case where the HREC has "noted" the approval of an External HREC, progress reports and reports

of adverse events are to be submitted to the External HREC only. In the case of Variations to the approved protocol, or a Renewal of approval, you will apply to the External HREC for approval in the first instance and then Register that approval with the University's HREC.

• *Monitoring of Progress*

Other than above, the University is obliged to monitor the progress of research projects involving human participants to ensure that they are conducted according to the protocol as approved by the HREC. A progress report is required on an annual basis. Continuation of your HREC approval for this project is conditional upon receipt, and satisfactory assessment, of annual progress reports. You will be advised when a report is due.

• *Reporting of Adverse Events*

1. It is the responsibility of the person **first named on this Approval Advice** to report adverse events.
2. Adverse events, however minor, must be recorded by the investigator as observed by the investigator or as volunteered by a participant in the research. Full details are to be documented, whether or not the investigator, or his/her deputies, consider the event to be related to the research substance or procedure.
3. Serious or unforeseen adverse events that occur during the research or within six (6) months of completion of the research, must be reported by the person first named on the Approval Advice to the (HREC) by way of the Adverse Event Report form (via RIMS at <https://rims.newcastle.edu.au/login.asp>) within 72 hours of the occurrence of the event or the investigator receiving advice of the event.
4. Serious adverse events are defined as:
 - Causing death, life threatening or serious disability.
 - Causing or prolonging hospitalisation.
 - Overdoses, cancers, congenital abnormalities, tissue damage, whether or not they are judged to be caused by the investigational agent or procedure.
 - Causing psycho-social and/or financial harm. This covers everything from perceived invasion of privacy, breach of confidentiality, or the diminution of social reputation, to the creation of psychological fears and trauma.
 - Any other event which might affect the continued ethical acceptability of the project.
5. Reports of adverse events must include:
 - Participant's study identification number;
 - date of birth;
 - date of entry into the study;
 - treatment arm (if applicable);
 - date of event;
 - details of event;
 - the investigator's opinion as to whether the event is related to the research procedures; and
 - action taken in response to the event.
6. Adverse events which do not fall within the definition of serious or unexpected, including those reported from other sites involved in the research, are to be reported in detail at the time of the annual progress report to the HREC.

• *Variations to approved protocol*

If you wish to change, or deviate from, the approved protocol, you will need to submit an *Application for Variation to Approved Human Research* (via RIMS at <https://rims.newcastle.edu.au/login.asp>). Variations may include, but are not limited to, changes or additions to investigators, study design, study population, number of participants, methods of recruitment, or participant information/consent documentation.

Variations must be approved by the (HREC) before they are implemented except when Registering an approval of a variation from an external HREC which has been designated the lead HREC, in which case

you may proceed as soon as you receive an acknowledgement of your Registration.

Linkage of ethics approval to a new Grant

HREC approvals cannot be assigned to a new grant or award (ie those that were not identified on the application for ethics approval) without confirmation of the approval from the Human Research Ethics Officer on behalf of the HREC.

Best wishes for a successful project.

Professor Allyson Holbrook
Chair, Human Research Ethics Committee

For communications and enquiries:

Human Research Ethics Administration

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Linked University of Newcastle administered funding:

| Funding body | Funding project title | First named investigator | Grant Ref |
|--------------|-----------------------|--------------------------|-----------|
|--------------|-----------------------|--------------------------|-----------|

Appendix 3.17. Ethics approval- DHUMC IRB

XX대학교 의과대학 부속 XX병원 기관생명윤리심의위원회

임상시험 심의결과 통보서

(회의) 13-12 차

1.일시 : 2013.04.16, 화, 17:00~18:00

2.장소 : 임상시험센터내 회의실

3.참석자(심사위원) : Panel C

4. (정원 : 12 명, 참석 : 7 명)

5. 회의내용(정규심사)

| | | | | | | | |
|--|--|--------|--------------------------|---|---------------------------------|---------------|------------|
| 수 신 | 책임연구자 | 성 명 | XXX | 소 속 | 간호부 | 직위 | 간호사 |
| | 지원기관 | 연구자주도 | | | | | |
| 연구제목 | 간호사의 암성통증 관리와 관련된 인식 및 역할에 대한 조사연구 : 비판적 문화기술지적 접근(영문 : Nurse's perception and roles for cancer pain management in the south korea healthcare context-critical ethnographic approach)) | | | | | | |
| 연구내용 | <input type="checkbox"/> 임상연구(<input type="checkbox"/> 의약품 일반명 : <input type="checkbox"/> 상품명 :) <input type="checkbox"/> 의료기기 <input type="checkbox"/> 의료행위(시술, 치료법 등) <input type="checkbox"/> 조직 및 혈액 <input type="checkbox"/> 생물학제재 <input type="checkbox"/> Stored Sample <input type="checkbox"/> 관찰연구(<input type="checkbox"/> 임상정보 <input type="checkbox"/> 임상시료 <input type="checkbox"/> 설문조사) ■기타 | | | | | | |
| 심의종류 | ■ 정규심의 <input type="checkbox"/> 신속심의 | | | 심의일 | 2013.04.16 | 승인일자 | 2013.04.16 |
| 접수번호 | 13-12-08 | 최초접수번호 | 13-08-05 (2013.03.19) | 최초 승인 번호 | ECT 13-12-08 (2013.04.16) | 중간보고 예 정 일 | |
| 출서류 | ■ 임상시험심사회의서 (Ver no.: CPN2013.0001-0001) | | | <input type="checkbox"/> 임상시험 시험자 자료집(대상의약품의 개요, 안정성 정보 포함) (Ver no.:) | | | |
| | ■ 임상시험 연구계획서 요약 (Ver no.:) | | | <input type="checkbox"/> 식약청 또는 주관연구기관 승인서 | | | |
| | ■ 연구계획서 (Ver no.:) | | | <input type="checkbox"/> 피험자 모집관련 서류 (Ver no.:) | | | |
| | ■ 증례기록지 (Ver no.: 면담계획서 대체) | | | <input type="checkbox"/> 피해보상규약 | | | |
| | ■ 피험자에게 제공되는 서류 : 피험자 설명문, 환자일지, 서면정보 (Ver no.:) | | | <input type="checkbox"/> 피해보험증 사본 | | | |
| | ■ 피험자 서면 동의서 및 설명문 (Ver no.:) | | | <input type="checkbox"/> 제조(수입)품목 허가증 사본 | | | |
| | ■ 연구자 최근 이력 또는 기타 경력에 관한 문서(교육 이수증 첨부) | | | <input type="checkbox"/> 이해상충 서약서 | | | |
| | <input type="checkbox"/> 연구비 산정내역서(원수, 연구비 없는 경우제외) | | | <input type="checkbox"/> 서면동의가 불필요한 경우 사유서 첨부 | | | |
| | <input type="checkbox"/> 임상시험이상반응보고서 (Ver no.:) | | | <input type="checkbox"/> 중간/ 지속심사 보고 (Ver no.:) | | | |
| | <input type="checkbox"/> 임상시험계획변경신청 (Ver no.:) | | | <input type="checkbox"/> 조기종료 (Ver no.:) | | | |
| <input type="checkbox"/> 종료보고 (Ver no.:) | | | | | | | |

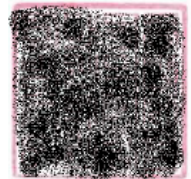
서울특별시 XXX XXXX XXXX, XXX-XXX XXXXXX병원 기관생명윤리심의위원회

XX대학교 의과대학 부속 XX병원 기관생명윤리심의위원회

| | | |
|------|--|--|
| 심의결과 | <input type="checkbox"/> 결과보고 (Ver no.: | <input checked="" type="checkbox"/> 기타 (심사지적사항 답변보고) |
| | <input checked="" type="checkbox"/> 승인 <input type="checkbox"/> 시정승인 <input type="checkbox"/> 재심사(보완) <input type="checkbox"/> 반려 <input type="checkbox"/> 승인된 임상시험의 중지/보류 | |
| 심사내용 | <심의결과> 만장일치 승인 합니다. | |

- 주) 1. 본 기관생명윤리심의위원회는 임상시험관리기준(KGCP) 및 국제임상시험통일안(ICH-GCP), 생명윤리 및 안전에 관한 법률 등 관련 법규를 준수 합니다.
2. 본위원회의 심의결정에 재평가 또는 변경이나 보완을 요청할 수 있습니다.
3. 본 위원회에서 지정한 중간보고시기에 중간보고서를, 연구종료시에는 종료 및 결과 보고서를 작성해야 지정일까지 제출하여 주시기 바랍니다.
4. 연구중에 중대한 유해사례(Serious Adverse Event) 발생시 연구책임자는 본 위원회에 즉시 보고해야 합니다.
5. 본 통지서는 KGCP 제 13 조 제①항에 따른 심사통보서로 사용할 수 있으며, 기관생명윤리심의위원회에기록된 내용과 동일 합니다.
6. 시정승인은 심사지적사항에 대한 답변서를 제출하여 승인 후 연구를 진행하여야 합니다.
(매주 목요일까지 제출, 신속심사 진행 : 원본 1 부, 사본 2 부)
7. 재심사는 심사지적사항에 대한 답변서를 보완하시어 자료를 제출하시기 바랍니다.
정규 재심사 진행 : 수정된 자료 원본 1 부, 사본 14 부 제출, 단, 의료기기 : 원본 1 부, 사본 11 부 제출)
8. 직인(서명)이 기재되지 않은 통지서는 무효입니다.
(위원회가 연구계획서를 승인하지 않은 경우 즉, 반려, 중지/보류의 결정을 통보 받은 경우 4 주 이내에최초심의와 동일한 방법으로 이의신청을 할 수 있습니다. 단, 동일연구에 대한 이의신청은 2 번까지 가능)
9. 헬싱키선언(제 19 조)에 따라 모든 임상시험은 첫 피험자 모집하기 전 공개적으로 접근이 가능한임상연구등록시스템(primary registry)에 등록하여 이를 공개하여야 하며, 예를 들어, 질병관리본부에서운영하는 임상연구정보서비스(CRIS, <http://cris.cdc.go.kr>)를 이용하실 수 있습니다.
- * 관련서식은 본원 홈페이지(<http://www.ksae.or.kr>)를 참조하시기 바랍니다.

XX대학교 의과대학부속 XX병원 기관생명윤리심의위원장 XXX



Appendix 3.18. Letter of confirmation

FACULTY OF HEALTH



Letter of Confirmation

I, (please print your name) am addressed as the Principle Investigator (PI) in Miran Kim's Institutional Review Board (IRB) application (approval No. ECT 13-12-08), as the IRB at the Ewha Woman's University Mokdong Hospital (EWUMH) requires one of its own staff to be placed as a PI in all research take field work at the institution including the research conducted by outsiders.

However, my role as a PI in Miran Kim's study is no more than a representative in terms of ethics approval at the EWUMH. I do not involve any other process such as collecting data, thus I do not have any rights for this research. It is purely Miran Kim's work throughout the entire data collection process.

Signature.....

Date..... 2013.12.14

Appendix 3. 19. A promise of confidentiality agreement form for the transcriptionist

FACULTY OF HEALTH



A Promise of Confidentiality Agreement form for the transcriptionist

I, (please print your name ..[REDACTED].....) will be the only person who transcribes the data interviewed by Ms Miran Kim and will consent to protect the privacy of both the interviewer and interviewees.

I understand all the ethical issues (confidentiality, anonymity, right to protection from harm) that could be drawn from the transcription. I will not disclose any of information to others with any personal details of the interviewees, which I may discover during transcription. I will also not copy any of the tapes interviewed for any other purpose.

Signature...[REDACTED]

Date...20/05/2013

Appendix 4.1. Superordinate themes, themes and subordinate themes of the findings

| Superordinate themes (ST) | Themes | Subordinate themes | | Relevant research questions |
|---|---|--|---|--|
| 1. CPMG Innovation: Is it evident? | 1.1. Seeds of innovation | 1.1.1. Guidelines for nursing practice | | c. What policies, procedures and guidelines are used in cancer pain practice? |
| | | 1.1.2. Lack of receptivity for change | | e. Is practice consistent (or inconsistent) with evidence-based international guidelines for cancer pain management? In what way is this so? |
| | | 1.1.3. Resources for the management of pain | | f. What are the facilitators/barriers to the uptake of the CPMG in Korea? |
| | 1.2. CPMG: Stimulus for changes | 1.2.1. Hospital accreditation | | |
| | | 1.2.2. Changes in leadership, changes in practice | | |
| | 1.3. CPMG: "We don't know much about it" | | | |
| 2. Nurses' usual practice for managing cancer pain | 2.1. Recognition of cancer pain | 2.1.1. Initiating nursing care: Use of greetings in pain assessment | | a. How do nurses provide care for the cancer patients who are experiencing pain in one acute healthcare setting in South Korea? |
| | | 2.1.2. Looking for cues and inferences relating to pain | | b. What do nurses do in their practice of pain management? |
| | | 2.1.3. Patients' experience and knowledge: Misconceptions and negative perceptions | | g. What are the barriers to cancer pain management and the use of the evidence-based guidelines? |
| | | 2.1.4. Patients' preferences for doctors, not nurses | | h. What are the facilitators to cancer pain management and use of the evidence-based guidelines? |
| | | 2.1.5. Nurses' misconceptions, misperceptions, and lack of knowledge | | |
| | 2.2. Nurses' responses and actions on recognition of pain | 2.2.1. Inadequate or limited assessment | | |
| | | 2.2.2. Influence of beliefs on inappropriate responses | | |
| | | 2.2.3. Pain assessment tools: Various and selective use and interpretation | | |
| | 2.3. Making decisions about pain management | 2.3.1. Reliance on pharmacological interventions | | |
| | | 2.3.2. Non-pharmacological interventions: Limited use | | |
| | | 2.3.3. Influential factors on decision-making | 2.3.3.1. Excessive workload limiting quality nursing care | |

| | | | | |
|---|--|---|---|--|
| | | | 2.3.3.2. Nurses' attitudes and assumptions | |
| | | | 2.3.3.3. Non-redeemable nursing activities | |
| | | | 2.3.3.4. Lack of patient education on pain management | |
| | | | 2.3.3.5. Inadequate education for nurses on pain management | |
| | 2.4. Evaluation of nursing actions: Guess work and minimal practice | | | |
| | 2.5. The dynamics: Family, MO and the nurse | 2.5.1. Family: Helpful/unhelpful | | |
| | | 2.5.2. Medical hierarchy and medical dominance | | |
| | | 2.5.3. Desire and reality: The dilemma for nurses | | |
| | | 2.5.4. Negative workplace behaviours among nurses | | |
| | 2.6. Roles and functions of nurses in usual practice for managing cancer pain | | | |
| 3. Nurses' experiences of managing cancer pain | 3.1. Professional dissonance: undervaluing nursing actions | | | d. What are the experiences of nurses in relation to cancer pain management? |
| | 3.2. Sense of powerlessness and frustration: Therapeutic intent vs. patient outcomes | | | |
| | 3.3. Anger and failure to embrace unique characteristics of patients | | | |
| | 3.4. Incongruence reflected in the professional mirror | | | |

Appendix 4.2. *Comparison of the contents of the CPMG and the current nursing practice*

| Contents of the CPMG | Nursing practice identified in themes |
|---|--|
| Introduction (intentions, need for guidelines, prevalence and classification of pain/causes of pain) | N/A |
| pain assessment (elements of basic assessment – PQRST (Position, quality, relieving or aggravating factors, severity and timing), history, psychological issues, misconceptions on pain and pain management, assessment tools, ongoing pain evaluation) | <p>2. Nurses' usual practice for managing cancer pain</p> <p>2.1.1. Initiating nursing care: Use of greetings in pain assessment 2.1.2. Looking for cues and inferences relating to pain 2.1.3. Patients' experience and knowledge: Misconceptions and negative perceptions 2.1.4. Patients' preferences for doctors, not nurses 2.1.5. Nurses' misconceptions, misperceptions, and lack of knowledge 2.2.1. Inadequate or limited assessment 2.2.2. Influence of beliefs on inappropriate responses 2.2.3. Pain assessment tools: Various and selective use and interpretation 2.3.1. Reliance on pharmacological interventions 2.3.2. Non-pharmacological interventions: Limited use 2.3.3. Influential factors on decision-making</p> |
| pain management (general principles of multidisciplinary approaches and family education/consultation; principles of use of pharmacological interventions; non-opioid/opioid analgesics including a flow chart to assist with making decision for using analgesics, equi-analgesic dose table, management of adverse effects, available opioid analgesic list; and adjuvant analgesics) | <p>3. Nurses' experiences of managing cancer pain</p> <p>3.1. Professional dissonance: undervaluing nursing actions 3.2. Sense of powerlessness and frustration: Therapeutic intent vs. patient outcomes 3.3. Anger and failure to embrace unique characteristics of patients 3.4. Incongruence reflected in the professional mirror</p> |
| cancer pain management for children | N/A |
| radiotherapy for cancer pain | N/A |
| nerve blocking for cancer pain management | N/A |
| treatment for intractable cancer pain | N/A |

