

Pain Resource Nurses: Believing the Patients, Believing in Themselves

Sandra Holley, PhD, ARNP, AOCN®, Susan C. McMillan, PhD, ARNP, FAAN,
Susan J. Hagan, MS, ARNP, Polly Palacios, PhD, and Deborah Rosenberg, PhD

Purpose/Objectives: To describe the experience of being a pain resource nurse (PRN), discuss the influence of the PRN's role on colleagues and patient care, and explore barriers to the PRN role.

Design: Qualitative, exploratory.

Setting: A Veterans Administration hospital in the southeastern United States.

Sample: 12 nurses who received advanced training in pain assessment and management attended focus groups approximately one year after assuming the PRN role.

Methods: Two focus group sessions, each with four to eight nurses. Each nurse was asked to describe her experience. Interviews were transcribed verbatim. Data were analyzed using Spradley's domain analysis for discovering processes and themes from the transcribed data.

Main Research Variables: The experience of being a PRN, the influence of the PRN on staff and patients, and barriers to the role and pain management.

Findings: The key processes that described the PRN experience were Believing the Patients (i.e., an awareness that nurses must have to effectively manage patients' pain) and Believing in Themselves (i.e., the PRNs gained authority as experts in pain management, accepted the responsibility of being champions in pain management, and gave themselves permission to make patients comfortable).

Conclusions: The pain-training course the PRNs received enabled them to practice as confident, credible, and empowered professionals. The awareness that they acquired during the course and the year of practice allowed the PRNs to be patient advocates, role models, and educators.

Implications for Nursing: The findings of this study indicate a high level of nurse satisfaction with the PRN role. Nurses with an interest and specialized knowledge in pain assessment and management at the unit level may greatly improve patient outcomes.

Key Points . . .

- Two key processes describe the experience of being a pain resource nurse (PRN): Believing the Patients and Believing in Themselves.
- Developing awareness and the increased practice of patient-centered care were the two instrumental principles that led to good pain management practices, understanding patients' experiences, and the information that other clinicians needed to possess to adequately control pain.
- Barriers to enacting the PRN role were self-doubt, negative judgmental attitudes of colleagues about patients in pain, resistance to the PRN's expertise, and uncaring attitudes from colleagues.

gill-Bourbonnais & Wilson-Barnett, 1992; McMillan, Tittle, Hagan, Laughlin, & Tabler, 2000; O'Brien, Dalton, Konsler, & Carlson, 1996; Vortherms, Ryan, & Ward, 1992).

The Joint Commission on Accreditation of Healthcare Organizations (1999) developed standards for the assessment and management of pain in accredited hospitals and other healthcare settings. The standards, which have been endorsed by the American Pain Society, indicate that personnel should

- Recognize the right of patients to receive appropriate assessment and management of pain.
- Assess the existence, nature, and intensity of pain in all patients.
- Record the results of an assessment in a way that facilitates regular reassessment and follow-up.
- Determine and ensure staff competency in pain assessment

Sandra Holley, PhD, ARNP, AOCN®, was a nurse research scientist at the James A. Haley Veterans Hospital (JAHVH) in Tampa, FL, at the time this article was submitted. Susan C. McMillan, PhD, ARNP, FAAN, is the Lyall and Beatrice Thompson professor of oncology quality of life nursing in the College of Nursing at the University of South Florida in Tampa. Susan J. Hagan, MS, ARNP, is a pain nurse practitioner, Polly Palacios, PhD, is a research associate, and Deborah Rosenberg, PhD, is a research associate, all at JAHVH. (Submitted December 2003. Accepted for publication February 17, 2005.)

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The panel that developed the National Comprehensive Cancer Network (2005) *Clinical Practice Guidelines in Oncology: Adult Cancer Pain* described the need for multiple modalities to adequately address the management of cancer pain. Although the guidelines do not discuss the role of various team members, they do suggest that modalities for pain management should include pharmacology, physical modalities, psychosocial interventions, radiation therapy, anesthetic techniques, and surgery as part of the total pain management program. In the interdisciplinary care team, nurses have the greatest minute-to-minute responsibility for pain assessment and management. When nurses become aware that a patient is in pain, their response is influenced by a variety of factors, including their knowledge and skill related to pain assessment and management, attitudes about patients with pain, and misconceptions about the use of opiates (Fother-

and management and address pain assessment and management in the orientation of all new staff.

- Establish policies and procedures that support the appropriate prescription or ordering of effective pain medications.
- Educate patients and their families about effective pain management.
- Address patient needs for symptom management in the discharge-planning process.

Many team members, including physicians, pharmacists, nurses, and patients, affect pain management (Paice, Mahon, & Faut-Callahan, 1991; Portenoy & Kanner, 1985; World Health Organization, 1996). However, among healthcare providers, nurses generally spend the most time with patients in a 24-hour period; therefore, they are in a central position to persuade patients who may be reluctant to take pain medications. Nurses also can advocate for patients so that appropriate pain relievers are prescribed. Thus, although nurses do not have complete control over patients' pain management regimens, they are in a position to have significant influence.

Barriers to Pain Management

Research has provided a variety of explanations for inadequate pain assessment and management, such as lack of pain management education, attitudes about patients in pain, and misconceptions about pain-relieving medication (Erkes, Parker, Carr, & Mayo, 2001; Howell, Butler, Vincent, Watt-Watson, & Stearns, 2000).

Pain Management Education

One common explanation for inadequate pain assessment and management is that nurses receive too little information about pain management in their nursing curricula. A survey of nurses in 23 countries revealed that more than half of the respondents did not receive pain management education in their nursing programs (Weissman, 1988). In surveys conducted in the Philippines and Australia, nurses reported that they believed that the pain management education in their basic programs was inadequate (Chiu, Trinca, Lim, & Tuazon, 2003).

According to Weissman (1988), since the 1970s, the focus on inadequate pain management has increased. Weissman called for the use of role models to emphasize the importance of pain management, teach staff interviewing techniques for assessing pain, serve as primary educators for pain management information, apply current standards, educate others that cancer pain can be managed effectively, and demonstrate that effective pain management results in positive patient outcomes in other areas such as sleep and nutritional status. Zalon (1999) assessed the content in 177 associate degree and 174 baccalaureate nursing programs in the United States and concluded that educational preparation in pain management was limited. The majority (86%) of nurses (N = 100) stated that they did not believe that their basic nursing education adequately prepared them to care for patients in pain (Fothergill-Bourbonnais & Wilson-Barnett, 1992). Ferrell, McGuire, and Donovan (1993) reviewed nursing texts published from 1985–1992 to determine the information that nurses were assigned to read about opioid addiction. They concluded that the information was inadequate at best and often inaccurate. The lack of preparation appears to be confirmed by additional studies that reported that practicing nurses do not have adequate knowledge about pain (Lebovits et al., 1997) or pain management (McCaffery & Ferrell, 1992).

A 40-hour training program for pain resource nurses (PRNs) was instituted by Ferrell, Grant, Ritchey, Ropchan, and Rivera (1993). Three months after the course, PRNs were more knowledgeable, had more positive attitudes, and had more positive pain management behaviors than prior to the course. Additionally, the PRNs were working actively to influence the pain management practices of their colleagues.

Knowledge and Attitudes

Researchers have indicated that nurses' decisions about the management of pain and pain-related complications are influenced more by their own attitudes and misconceptions than by a thorough assessment of a patient's current status. Although a great deal of attention has been focused on negative reports of nurses' management of pain, little work has been conducted to change nurses' pain management behaviors (Kravitz, Delafield, Hays, Drazin, & Conolly, 1996; McMillan & Tittle, 1995; Miaskowski et al., 2001; Portenoy & Lesage, 1999). Numerous studies completed in the United States and other countries have revealed serious deficits in nurses' knowledge of pain management. Participants in these international studies were oncology, intensive care, hospice, and cardiovascular nurses (de Rond et al., 2000; Erkes et al., 2001; Plymale et al., 2001; Watt-Watson, Stevens, Garfinkel, Streiner, & Gallop, 2001). Thus, the barrier of inadequate knowledge related to pain management appears to be widespread.

Not only have lack of knowledge and insufficient assessments been implicated in inadequate management of pain, but nursing attitudes have been implicated as well. Nurses appear to hold a variety of attitudes toward pain management that interfere with appropriate responses to patients' complaints of pain. In a study of 85 nurses caring for patients with cancer in two veterans hospitals, undesirable attitudes toward pain management or patients in pain were demonstrated. More than 22% of the nurses indicated that they would reduce a patient's reported pain rating when charting it, 89% believed that they should have more control over the timing of a patient's pain medication than the patient or family, and 84% believed that steady state analgesia achieved through around-the-clock dosing (rather than as needed) was undesirable. About 56% of the nurses exhibited misconceptions about addiction, and 51% indicated that their estimation of pain was more valid than the patient's (McMillan, Tittle, Hagan, Laughlin, et al., 2000). Dalton et al. (1998) found that, among a group of 67 nurse respondents, 34 believed that patients should be pain-free. Furthermore, most of these nurses confirmed that their own beliefs about pain influenced their assessments of patients.

Summary

A number of factors have been identified that contribute to nurses' inadequate management of pain. First, in the United States and worldwide, very little information about pain management is incorporated into nursing curricula (Chiu et al., 2003; Weissman, 1988). As a result, nurses have limited knowledge of pain and pain management and possess misconceptions that interfere with adequate management (de Rond et al., 2000; Erkes et al., 2001; Plymale et al., 2001; Watt-Watson et al., 2001). Nurses tend to assess pain minimally or avoid it completely and often substitute their

own judgment for the patient's. Little information is charted, and what is charted tends to be inaccurate (McMillan, Tittle, Hagan, & Laughlin, 2000). As a result, PRNs, acting as role models on inpatient units, might help nurses to overcome these barriers.

The project being reported here was part of a larger study that educated nurses to become PRNs in a 32-hour advanced pain management course (see pages 835–842 for a discussion of the course). The purpose of the pain management course was to enlist PRNs to serve as role models and educators on their respective nursing units where they served in the PRN role for more than a year. Nurses self-selected or were nominated by their nurse managers (who also confirmed the self-selected nurses) because of their experience and interest in pain management.

The aims of this study were to obtain detailed information using focus groups to describe the experience of being a PRN, the PRNs' impact on colleagues and patient care, and barriers that PRNs encountered as part of their role.

Methods

Sample

Participants in the PRN-training program who had functioned on their individual nursing units as PRNs in the past year were invited to attend focus group luncheons to discuss their experiences. Twelve nurses attended two separate focus groups. All of the nurse participants were female RNs in their mid- to late 40s and were well educated. Most had either baccalaureate or master's degrees.

Procedures

This study was approved by the affiliated university's institutional review board. At the beginning of each focus group, the facilitator explained the study and obtained written informed consent. A nurse researcher and a master's-prepared health science specialist familiar with focus group methodology conducted the groups. Each of the PRNs was invited to describe her experience in turn. The sessions, each lasting 60–90 minutes, were audiotaped. To facilitate the discussion, the researchers asked questions such as, "What was the PRN experience like?" "What was the impact on colleagues and patient care?" and "What barriers were encountered?"

Data Analysis

Audiotapes were transcribed and verified for accuracy. A nurse researcher, an anthropology researcher and project manager, and a master's-prepared health science specialist read the transcripts multiple times one to two months after the focus groups were held and when preparing this article and reached a consensus using Spradley's (1979) domain analysis for discovering processes and themes from transcribed data. Three focus group members also read the transcripts, discussed the themes with each other and the principal investigator, and validated the analysis.

Results

Of the 18 PRNs in the original study, 12 returned to attend two separate focus groups. The pain preparation course introduced the PRNs to evidence-based, patient-centered, pain management concepts. Two key processes were discovered

that described the experience of being a PRN: Believing the Patients and Believing in Themselves.

The Experience of Being a Pain Resource Nurse

The PRNs' ability to effectively manage pain resulted from the training course as well as practice over a year's time. Pain no longer was managed by simply giving pain pills or injections. In Believing the Patients, the PRNs had to assess patients' reports of pain ratings, determine proper interventions, and evaluate the outcomes of the interventions. The course enabled PRNs to practice as confident, credible, and empowered professionals. The awareness that they acquired during the course and the year of practice allowed the PRNs to be patient advocates, role models, and educators. Figure 1 illustrates the key processes and themes derived from the data.

Key Process: Believing the Patients

Believing the Patients is defined as the specialized awareness about an individual's pain experience that nurses developed as a result of their own improved skills and confidence in pain management. Believing the Patients is critical because it allows nurses to advocate for patients' pain management with physicians, family members, and nurse colleagues. This approach emphasizes a patient-centered approach that is necessary for adequate pain management.

The process of Believing the Patients began with an awareness of the nurses' sharing, questioning, identifying, and understanding their own biases; recognizing a lack of knowledge; and realizing that past practices were not effective. All of the participants in the group nodded in agreement when one participant stated

There were so many things that we learned in the course. We sat there 32 hours and had a lot of sharing experience during that time. I really tried to understand seriously what were our biases and what holds us back. Are we going to say to that patient, "Do you have pain?" Are we going to make him have pain just because we asked a question? Or does he have a right to be asked? And let him answer, and believe him. Believing the Patients was a big thing. I had not found that people wanted to believe patients. The nurse doesn't always know what's going on inside that patient.

Another participant said, "We learned about pain. Not only that it needs to be addressed, but that it needs to be assessed." Another said that the course helped the nurses "give themselves permission to make these patients comfortable."

In developing the PRNs' belief of patients' pain, the educators in the training program discussed the act of introspection, identification of misconceptions, and awareness of a patient's experience by asking (i.e., assessing) about that pain. To understand a patient's pain, nurses must assess the pain, believe the patient's verbal characterization of the pain, provide an intervention to relieve pain, and evaluate the level of pain relief. For the nurses, Believing the Patients and managing patients' pain became an ethical imperative.

Key Process: Believing in Themselves

In Believing in Themselves, the PRNs gained authority as experts in pain management, accepted the responsibility of being champions in pain management, and gave themselves permission to make patients comfortable. Asking for and be-

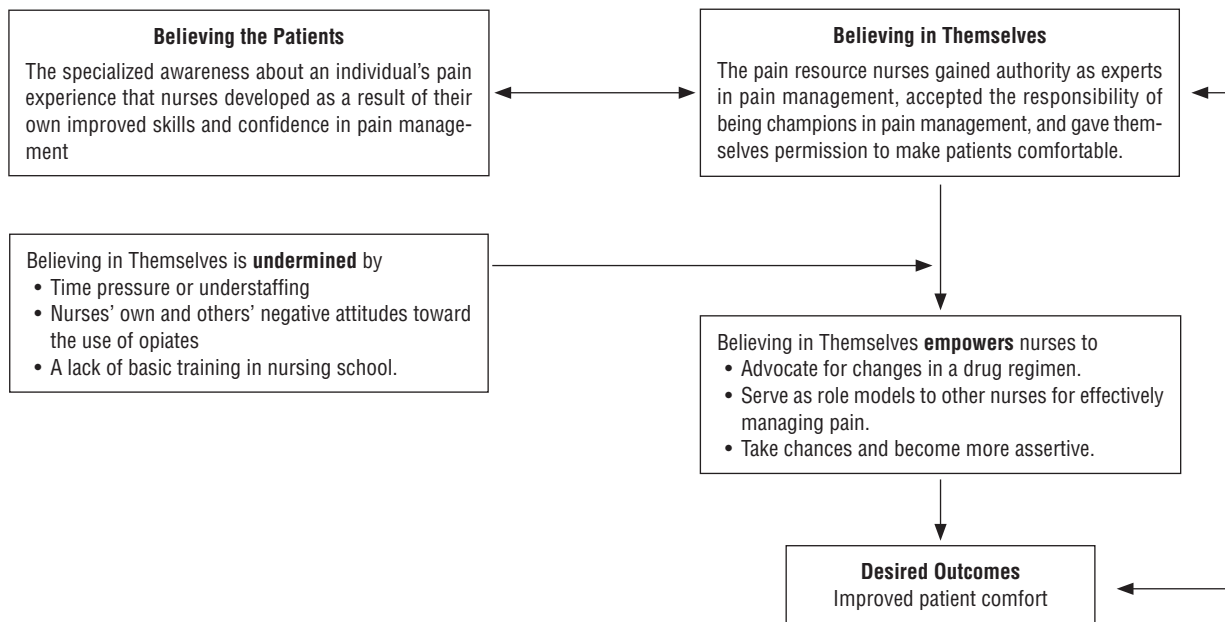


Figure 1. Becoming an Advocate for Patient-Centered Pain Management

believing patients' report of pain intensity were the first steps in Believing in Themselves as expert pain management nurses. One nurse explained the confidence gained by the nurses in the program.

I know I've used the pain team many times. And I had residents [doctors] angry with me [who said], "Why did you call [the pain team]? You had no right. This is unacceptable that you did that." What I would tell them is, "No, it's unacceptable that this man has been laying here for three hours in pain and you refused to address it." And I think once you approach [medical colleagues] as professionals and they know that this is not acceptable and you're not going to tolerate it, then they're more apt to treat pain and then it becomes a habit.

Another nurse explained her advocacy for patients in pain.

I found the experience of having gone to the training to be very enlightening. I think it made me very much more secure as a nurse in confronting doctors and colleagues. I used to work the night shift, and we had a lot of patients with pain, and there are a lot of prejudices like, "That patient is medication-seeking." I had the conviction that I was going to stand up for the patient. I asked a nurse one night, "How was the patient doing? Had he been relieved of his pain?" He had just had surgery that day, and the nurse said, "I didn't ask him." I said, "Well you need to ask him." And she refused to do it. I went back in, the patient was awake, and I asked him, was he having pain, and he said yes, and I took care of it.

Believing in Themselves was reinforced by positive pain outcomes for patients and patient feedback. Believing in Themselves allowed nurses to take chances, become more assertive, and be role models. In addition, pain management education led nursing and medical colleagues to perceive the PRNs as credible. The nurses took responsibility for

increasing their own knowledge and skill and helping other staff to manage pain more effectively. Being a role model was a concrete way of becoming a leader in pain management. The statements by the PRNs illustrate how perceptions of successful pain management become internalized and implemented. The importance of pain assessment was the basis for good practice and gave the nurses a tool to use in advocating for the relief of patients' pain.

Pain Resource Nurses' Impact on Colleagues and Patient Outcomes

Throughout the PRN education course, participants were taught to model their pain management behavior to other nurses, students, and physicians. As the nurses' use of the modeling behavior increased, so did their expertise. Many examples of modeling behavior were given, including the following.

I think one of the things, from an education standpoint, that I got is that I was just not aware of the bias that medical people have about people in pain . . . drug-seeking or the lack of knowledge in treating patients. . . . [They didn't know] that it's okay to go ahead and give somebody an IR [immediate release] medication 15 minutes early, but it's not okay to give the sustained release [SR] an hour early. We had those . . . they can have the IR but the SR, no . . . because at 7 tonight when that thing's worn off, that guy's going to be in big trouble. Give him the IR. [Repeating the concern of a colleague] "Well, we can't do that. It's 15 minutes early." Well, I'll do it if you're not comfortable.

Because of their educational preparation, the PRNs expressed confidence in their pain management skills and felt responsible for seeing that patients received the pain relief that they needed and deserved. The nurses also used modeling behaviors for educating, proving themselves, and

disseminating information to their colleagues about pain management. One nurse said

I work in the emergency room. What I changed was our assessment plan. We implemented the pain factor on our assessment plan and also on our auditing form. And I have a bulletin board that I do every month, and every month is a new article on pain. I get it out of a journal or the newspaper. One of them was made into a poster, and it was recently in one of the nursing journals. My poster. My war on pain. We do a lot of patient education in the emergency room now. We explain about the pain medication that the patient is getting, the consequences of taking the pain medication, like constipation. A lot of patients don't realize that a lot of narcotics are constipating, so therefore they either have to increase their fluids or take a stool softener or [drink] prune juice. Attitudes have changed a lot in the emergency room [ER] since I took the course. I mean, it really made a big difference, I think, and people are addressing pain on every patient that comes through the ER. It has changed a lot.

Another nurse shared a memorable teaching moment.

We preach so much about doing pain interventions that we sometimes have slacked on the assessment part. We had a cancer patient [on the unit], and I had a student nurse, and it was a wonderful teaching experience for her because she came down and said, "Mr. So-and-So is in pain." The nurse taking care of him was in the break room and said, "Somebody give him some morphine." I just sat there a minute to see if anybody was going to do anything. Finally I said, "Come on. Let me teach you something." And we went back and I said, "Where is your pain?" He pointed to his chest and he goes right here, and I said, "Is it radiating?" And he said, "Yes, it's going down my left arm." This guy was in the middle of an MI [myocardial infarction], and had the other nurse come off her break, she would have probably just given him morphine and never have assessed what was going on with his pain. . . . We all knew he had pain, but every time they complain of pain, you need to assess it, and it could be something different.

Using modeling behaviors illustrates the impact that the PRNs had on patients, students, and nurse and physician colleagues. Their confidence, responsibility, increased effectiveness, credibility, and ability to be patient advocates were ever-increasing, which influenced and reinforced their professionalism.

Barriers to the Pain Resource Nurse Role

Although all of the participants found their PRN roles to be very positive, they did face some resistance. Barriers, including self-doubt, negative judgmental attitudes of colleagues about patients in pain, resistance to the PRNs' expertise, and uncaring attitudes from colleagues, were reported. One nurse shared her feelings of self-doubt as a novice PRN and how she overcame them.

It's pretty scary to go through. What did we go through? A month's training? And then they tell you, now you're this pain resource nurse and you're expected to deal with the doctors, deal with the staff, and you think, "I can't do this!" But you know what? We're not alone. We're all together in this, and there are a lot of resource people in

this hospital, and that's what I think people need to know. You're not in this by yourself. Sometimes it seems like that. You don't need to know all the answers. There are people who have the answers.

Another nurse considered barriers to good pain management to be a result of destructive nursing attitudes. She said

Actually, I think nurses are their own worst enemy. They're very reluctant to accept what the patient says is their pain level, and the bottom line is that's what you do. I did not find that people wanted to believe patients; they felt that the nurse knows best. And that's not true. The nurse doesn't always know what's going on inside that patient. But these people didn't like being told that, and I wouldn't quit. The doctors listened to me, and they did everything that I would ask because I would give them as much background information as I could.

By modeling behaviors of good pain management, persevering, Believing in Themselves, and receiving support from upper management, the PRNs were able to win over colleagues and provide their patients with the pain relief they needed.

Discussion

The aims of this project were to obtain detailed information using focus groups to describe the experience of being a PRN, the PRNs' impact on colleagues and patient care, and barriers the PRNs encountered in their PRN role. Awareness of the need for patient-centered care was an essential underlying principle that led to good pain management, an understanding of what the patient was experiencing, and what others needed to know to adequately control pain. This mode of assessment and pain management also is patient centered, a concept that is essential to good nursing practice.

Two key processes were discovered that characterized the PRN experience: Believing the Patients led to Believing in Themselves. The importance of pain assessment was the basis for good practice and gave the PRNs a tool to use when advocating for patients' pain relief. The PRNs had a concrete tool (i.e., the patient's pain rating on a 0–10 scale) to assess, intervene, and evaluate the outcomes of pain interventions. A patient's subjective report of his or her pain is the most reliable form of pain assessment (Fisch & Cleeland, 2003). Asking for and believing patients' reports of pain intensity were the first steps to Believing in Themselves as expert PRNs. The nurses were confident, empowered, credible advocates for patients in pain.

The subthemes of Believing in Themselves were role-modeling behaviors, gaining confidence, taking responsibility, increasing the effectiveness of pain management, establishing credibility with colleagues, and becoming patient advocates. The importance of Believing the Patients and Believing in Themselves resulted from a 32-hour pain management educational program as well as the PRNs' success with pain management over a year. The evidence-based pain management concepts that the PRNs learned were internalized and implemented into their respective nursing units' practices through using modeling behaviors.

The training course clearly empowered the PRNs to practice as pain experts. They found the empowerment rewarding and had the satisfaction of seeing improved patient outcomes. The knowledge they obtained allowed them to model behaviors and act as leaders to improve their patients' pain relief.

Limitations

This study is limited by its small sample size. At about the time that the PRNs started practicing as resources on their respective units, the Veterans Administration instituted a policy indicating that pain is the fifth vital sign, which may have influenced some of the changes in pain management by the staff. Although the policy was established, the PRNs were able to educate staff members about why it was needed and how it pertained to staff nurses for improved patient pain outcomes.

Implications for Practice

The key processes of Believing the Patients and Believing in Themselves helped to demonstrate the power of patient-

centered care. The findings of this study indicate a high level of nurse satisfaction with the PRN role. The PRNs believed that they had a positive influence on colleagues and patient pain management.

Nurses care for an ever-increasing aging population with chronic conditions, many of which also include pain as a major sequelae. For this reason, specific education on pain management must be a requirement for practice. Nurses with an interest in and specialized knowledge about pain, pain assessment, and pain management at the unit level may improve patients' pain outcomes.

Author Contact: Susan C. McMillan, PhD, ARNP, FAAN, can be reached at smcmilla@hsc.usf.edu, with copy to editor at rose_mary@earthlink.net.

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