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Togethering and positioning: The experience of registered nurses of clinically inflicted pain

Hannelore Gertrud Krieger

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**TOGETHERING AND POSITIONING:
THE EXPERIENCE OF REGISTERED NURSES OF
CLINICALLY INFLICTED PAIN**

By

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B.S., Nursing, University of New Mexico, 2000
M.S., Nursing, University of New Mexico, 2005

DISSERTATION

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ABSTRACT

This study explored the experience of registered nurses of clinically inflicted pain (CIP). This study showed that the experience of nurses is distinctly different from the experience of patients. This study revealed the constructed nature of CIP and nurses estimation of CIP’s painfulness. Nurses utilized a number of processes to alleviate their discomfort associated with having to inflict pain. Nurses also utilized processes that effectively changed CIP to mean something other than pain, specifically the processes of unmaking the patient experience and remaking of CIP. Some nurses were conflicted at least some of the time about CIP. This created a theoretical problem, which led to the discovery of the theory of *togethering*, the bringing together of the professional nurse (defined solely by education, training, and skill) and the nurse person (broadly defined as a human being who is also a professional nurse). The nurse person positions the professional nurse in the various processes utilized by nurses, a process I called *positioning*. I argue that it is the nurse person who distinguishes the professional nurse. The theory of *togethering* defines nurses by who

(or what) they are not by their relationship to patients and thus contributes to nursing theory.

I believe this study may have important implications particularly for nursing education.

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Chapter 1 Introduction

This study examined the experiences of registered nurses who inflicted unintended pain as they provided common nursing care. I differentiated between the experiences of nurses, the experiences of patients, and the co-created situation in which the infliction of pain took place (henceforth referred to as clinically inflicted pain, or CIP); I distinguished between the actors (nurse and patient) and the act (CIP).

Nurses cause CIP by carrying out procedures. To a degree, nurses have control over the intensity and/or duration of CIP. Nurses also witness the effects of the procedures on patients and are exposed to, and at times the target of, patients' responses. Nagy (1994) provided a particularly poignant example: "He abused me the whole time with lovely four letter words and everything. But then the hatred in his eyes . . . If I didn't stand further than his arm length away I would have been hit numerous times" (p. 150).

In a clinical setting, patients ought to consent to procedures carried out by nurses, and patients' active cooperation is often required. I made the assumption that a patient's consent distinguished CIP from other injurious behavior, e.g., battery. Battery is defined as "a physical act that results in harmful or offensive contact with another person without that person's consent" (Legal Information Institute, 2010, para. 1).

Two meanings of CIP were identified in the literature. First, CIP was used to refer to the actual sensory experience of pain as a result of a nursing procedure. Second, CIP was used to refer to the relationship between the nurse and the patient, described by Fagerhaugh and Strauss (1977) as an implicit contract and by Madjar (1998) as a social situation. Nurses cannot carry out procedures without some form of interaction with the patient, and this interaction, in turn, affects nurses, captured by Nagy (1994, 1998, 1999) as an

interrelationship between nurses and patients. Madjar poignantly described this interrelationship (adversely, in this particular instance), noting that “However justifiable the pain we must inflict, we should never forget that all pain hurts. When inflicted with technical detachment and without feeling or regret, pain dehumanizes not only the person who must endure it, but also the person who inflicts it” (p. 160). Figure 1 presents a depiction of the distinction being described:

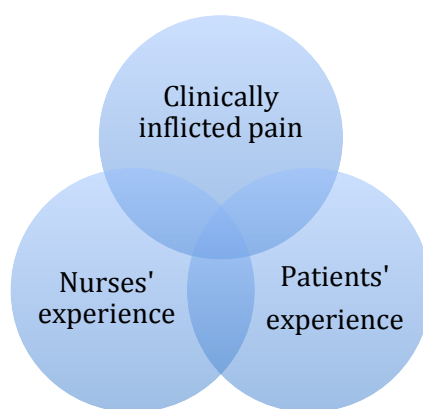


Figure 1. Distinction and overlap between CIP, the nurse’s experience, and the patient’s experience.

My intent was to focus on nurses, and as such, I chose a particular, one-sided perspective. The study was aimed at routine nursing care and common nursing procedures. See Appendix A for differentiation between a medical procedure and a nursing (nonmedical) procedure. While there are extraordinary situations, e.g., emergencies in which inflicted pain is openly acknowledged and disregarded as irrelevant under the circumstances, I viewed emergencies as distracting exceptions to the far more common and widespread occurrence of commonly carried out procedures associated with CIP. At the time of writing Chapter 1, it was not clear whether these special clinical situations should be excluded. Given the paucity

of knowledge with regard to CIP I felt that an exclusion of nurses experiences related to CIP in emergency situations was premature prior to conducting the study.

Painful nursing procedures range from seemingly benign procedures, such as turning a patient in bed or measuring blood pressure, to more invasive procedures, such as administering injections, changing wound dressings, or inserting tubes. Madjar (1998) noted, “If there are important aspects of patients’ lived experience that require further research, careful explication, and deeper understanding, there are also important aspects of nurses’ experience that deserve similar attention” (p. 177).

Nurses inform each other about CIP. Nurses actively transmit norms, values, beliefs, attitudes, and practices through verbal counsel and modeled behavior. I made the assumption that there was a nursing discourse pertinent to CIP. Price and Cheek (1996) explained, “Discursively constructed refers to how certain ways of thinking (discourses) construct understanding of reality and exclude other ways of thinking about the same reality” (p. 899). I viewed discourse not just as an abstract sphere, but also as having real effects. Ward (2010) noted that discourse is historically particular, variable from culture to culture, and subject to change.

This study was conducted to shed light on this nursing discourse (or lack thereof). Many questions pertinent to nurses arose within the context of CIP: What was the role and/or responsibility of nurses with regard to CIP? Who or what determined this role? Nurses changed, possibly as a result of CIP; however, what exactly changed, what or who facilitated this change, and what did this change say about nursing? Who was to say what was pain or painful, tolerable, avoidable, and/or without consequences? Was there a need for pain? Was there meaning to pain that was unrelated to the essence of pain (i.e., the painfulness of pain)?

How did nurses make decisions particularly related to pain? What made nurses perform these procedures? What were the loyalties of nurses? Where did ethics and morals fit in? Was CIP an act of violence or aggression? Where did the association with torture come from?

I chose grounded theory (GT) methodology for this study. Based on the foundational underpinning of GT, the research question was purposefully kept broad: What was the experience of nurses who while providing care also inflicted unintended pain? I developed an initial questionnaire (see Appendix F) to comply with Internal Review Board requirements. I specifically chose GT in order to develop a theory that would: first, explain and predict the behavior of nurses related to inflicting pain; second, be useful for the advancement of nursing theory; and third, have practical applications for nurses as well as for patient care (Glaser & Strauss, 1967/2009). Given the importance that Patton (2002) placed on description, specifically, that “description forms the bedrock of all qualitative research” (p. 438), I subsequently included a descriptive section.

There were several reasons for undertaking this research, foremost that little was known about nurses as pain inflictors; what was known was that CIP was problematic to some but not to all nurses (Fagerhaugh & Strauss, 1977; Madjar, 1998; Nagy, 1994, 1999). This research was undertaken in the hope of shedding light on this unexplored phenomenon and, ultimately, to assist nurses in addressing this professional issue. I viewed this study as a proactive step, as it will allow nurses to address a clinical phenomenon before it might become a legal issue. It was my hope that the knowledge generated from this inquiry will afford new insight and thus inform nursing practice, theory, and education.

Problem Statement

Nurses, while providing nursing care, unintentionally inflict pain. Some nurses describe inflicting pain as problematic (Hinsch, 1982; Sandroff, 1983), while others do not (Kornhaber, 2009; Madjar, 1998; Nagy, 1994, 1999). Nurses go through a process of adaption and adjustment (Bernstein, 1976). Adaptive responses include distancing oneself from the patient's pain, engaging with the patient's pain, seeking social support, and reconstructing the nurse's core role (Nagy, 1999). It appears that nurses' responses are learned and change over time (Bernstein, 1976; Madjar, 1998; Nagy, 1999). Nurses describe these adaptive responses as coping and as a skill (Madjar, 1998). Nurses associate their conduct with violence, aggression (Dind, 1989), and torture (Schroeder, 1992). Inflicting pain is also a tool for nurses that is essential to their work (e.g., the Glasgow Coma Scale). Perry (1984) hypothesized that inflicted pain might fulfill a psychological need for nurses. Perry hypothesized, "The patient's pain "served two functions. First, it made the patient a definable being, a person separate from others, and second, the pain helped [nurses] that this 'object' was alive" (p. 311). In summary, CIP is a complex, unexplored aspect of nurses' work that affects nurses. Please note that affected is not synonymous with conflicted. Nursing theory and education offer little or no guidance on how to address the issues related to CIP.

Statement of Purpose and Research Questions

The purpose of this GT study was to explore the experiences of nurses who inflicted pain while providing nursing care. It was anticipated that through a better understanding of this phenomenon, the issues and challenges nurses face could be made explicit and a theory could be developed that explains nurses' behavior within the context of CIP. GT

methodology typically starts with a general question to capture the main concern of the participants, which is unknown at the onset of any given GT study. Subsequently, although I had raised a number of questions, the general question that I needed to ask remained: What was the experience of nurses with regard to CIP? As part of the dissertation proposal I expanded the research questions to include: What were nurses' experiences with regard to CIP? How did nurses explain CIP? How did nurses, if indicated, reconcile and/or justify CIP? In addition, I developed a questionnaire as required by the Internal Review Board (IRB). The questionnaire guided the initial interviews (see Appendix F).

Assumptions

Based on my experience as a RN and the literature, I made the following assumptions: first, nurses are affected by CIP; second, a nursing discourse informs nurses about CIP, and lastly, nurses are sanctioned with regard to CIP. Ultimately, CIP is widely accepted as unavoidable thus justified, and thus inflicting pain goes unquestioned.

The Researcher

I have been working in some capacity in nursing since 1978 in a variety of settings including oncology, orthopedics, various critical care units, cardiac rehabilitation, diabetes education, anticoagulation management, home health care and hospice nursing. I have been an instructor in an associate degree, nursing program. Most recently, I have worked as an advanced-practice registered nurse with prescriptive authority, providing primary care to forensic psychiatric patients. I obtained a nursing diploma in 1982 in Germany and, since coming to the United States, have obtained baccalaureate and master's degrees from the University of New Mexico, College of Nursing. I brought practical experience as a working

professional to this study and possess both the knowledge and the understanding of the environmental context.

I believe that my German heritage, particularly the crimes committed during the Nazi regime, sensitized me to raise the question of CIP. My father was a member of the Sturm Abteilung (a paramilitary group) during the Nazi regime in Germany. As a juvenile, I wrestled with the question: How could ordinary people be capable of such horrid crimes? Two books were particularly influential: Hannah Arendt's *Eichmann in Jerusalem: A Report on the Banality of Evil* and Mary Daly's *Gyn/ecology: The Metaethics of Radical Feminism*. Arendt (1963/1994) introduced the idea that "evil" could be carried out by ordinary human beings. Evil could result as a consequence of following orders. Evil could be disguised as lawful and "right." Arendt noted that people, believing they were doing "the right thing," were capable of doing anything (including mass murder). Another observation by Arendt appeared equally important: The abhorrent nature of killing other human beings was openly acknowledged by Nazi officials, and lower level executives were credited for their "sacrifice" of carrying out a task that would purify the German people (Volk). Daly (1978) put forth the idea that violence could be carried out as a culturally sanctioned act. Daly noted that this could only be accomplished by shaping perception, described by Daly as "deceptive myths" and "emotional complicity," which allowed people "to perform uncritically their preordained roles" (p. 109). These ideas continue to disturb me to this day.

As a nurse I have inflicted pain on numerous occasions, which has been both problematic and unproblematic at different times in my career. When CIP was problematic, it needed to be resolved *somehow*. When I first began articulating the question of CIP, I called it cruelty in nursing: I recognized the use of violence in common nurse-patient interactions

(i.e., holding a patient down to carry out a procedure). The following paragraph is an excerpt of the preface I wrote in 2005 as part of my master's thesis (Krieger, 2005). It captured the anguish I felt during some of the listed instances; the language at times was graphic, but it was left intact to preserve the emotional quality. All of the incidents described were considered routine nursing care. What follows is an abbreviated excerpt:

I became a nurse because I wanted do “good.” My first unit was on an oncology floor, where I was the nurse for Ms. S. When we turned her in bed, I heard her collarbone break. Ms. S’s scream still echoes within my soul. I remember Mr. L. in the intensive care unit, a man left without a voice from intubation, his face bloodied from unsuccessful attempts to insert a nasogastric tube. He wrote, “I’d rather die than do this again.” We tied him down and tried again. I remember the young trauma victim who had no name; his last word was “mother” as he bled to death as we were putting in a chest tube. I remember the demented concentration camp survivor who needed a bladder catheter; it took four of us to hold her down as she was reliving some unnamed horror. I remember my first burn patient, who was burned beyond a chance for recovery. We kept him alive for a week, as he twitched with pain to his last day. I remember the 14-year-old boy who was resuscitated in the operating room after major arteries in his body were clamped off. It took him nearly two weeks to die a miserable death as his guts were rotting inside. The 2-year-old in need of immunization, her face distorted by fear... (pp. 5-6)

Those experiences led me to ask some uncomfortable questions, such as: How can I (considered an ordinary person), intending to do “good,” do something so “horrible”? The current study was also certainly an attempt to make peace with and possibly reconcile this

question. Madjar (1998) noted that some nurses resort to dehumanization (of patients). Dehumanization affects both the patient being subjected to pain as well as the nurse, the inflictor of pain. I conducted this study with the explicit hope to benefit nurses as well as patients, but also, and arguably more importantly, to give back to the profession and initiate a discussion in which both nurses and patients only have something to gain.

I was aware that the same experiences that were valuable in providing insight also could amount to biases, affecting my judgment when coding and interpreting the study's findings (Bloomberg & Volpe, 2008). Glaser (1978, 1992) cautioned that the sensitivities associated with being an expert in one's field did not amount to theoretical sensitivity, defined as the ability to conceptualize, and warned that being an expert could set up the researcher for "empirical description with some preconceived conceptual description" (1992, p. 27). I took the following procedural safeguards: I made my assumptions and theoretical orientation explicit at the onset of this study, I remained committed to ongoing self-reflection by way of memoing and journaling, I strictly adhered to the vigorous processes associated with grounded theory, and I engaged in professional dialogue with colleagues and advisers to address the concern about subjectivity and to strengthen the credibility of this research.

Rationale and Significance

It has been my experience that fellow nurses lost interest in the question of CIP when I did not have an answer regarding what to do about CIP; notably, the discussion ended for a lack of answers. My interest was aimed at wanting to understand this common aspect of nursing care from the inflictors' (nurses') experiences. Although I believed that CIP could not be eliminated, it was my hope that an increased understanding of the processes pertaining to CIP could provide guidance, particularly for nursing education. When I was teaching

entry-level nursing students, the utilized textbooks did not address pain management of CIP. It was my hope that a better understanding could inform not only nursing education, but also could advance nursing theory and affect nursing care, particularly in the form of policies and procedures that build the foundation for professional standards and accountability. Although this research was aimed at nurses, ultimately it was my hope to alleviate pain for patients across disciplines and health care settings.

Chapter 2 provides a review of the pertinent literature. The literature review commences with what is known about CIP in order to provide context. The beginnings of scholarly exploration dated back to 1977 with the work of Shizuko Fagerhaugh and Anselm Strauss. Sue Nagy (1994, 1998, 1999) and Irena Madjar (1998) explored CIP in subsequent studies. I introduce other terminology pertaining to CIP, touch on the role of the health care institution, show the empiric nature of CIP, provide estimations of CIP's prevalence, and conclude with the puzzling characteristic of the under-recognition, or non-recognition, of CIP. I briefly introduce the patients' experience by listing distinguishing attributes: first, between the experience of nurses and patients and second, of CIP as compared to other pain.

The main part of Chapter 2 addresses nurses and nursing in the context of CIP: Is CIP a stressor for nurses, nurses' work, personal opinions, resocialization, and adaptive responses to CIP? I present assumptions made by nurses, particularly the assumed inevitability of CIP. Nurses' use of CIP as a clinical tool raises epistemological and ontological questions with regard to pain. I address the question of what propels nurses to carry out painful procedures and place CIP in an ethical-moral context. I conclude with analogies drawn to violence, aggression, and torture.

I address methodology and methods in Chapter 3; findings in Chapter 4; and analyses, interpretations, and a synthesis of the findings, including study limitations and potential future research, in Chapter 5.

Chapter 2 Review of Related Literature

Little was known about the experiences of nurses inflicting unintended pain. The dearth of literature forced me to make inferences from the literature about the experience of nurses in the context of CIP. I felt it was important to begin Chapter 2 by presenting what was known about CIP in order to situate the research into clinical practice and to provide context for the experience of nurses. Chapter 2 is structured like a discussion in an attempt to summarize what was known, to raise questions, and to dive into some controversies. I introduce the experience of patients by listing differentiating attributes of how patients' experiences are different from the experience of nurses. The last and main section of Chapter 2 addresses a broad spectrum of issues related to nurses and the discipline of nursing through the lens of CIP.

Clinically Inflicted Pain

Fagerhaugh and Strauss (1977) introduced CIP. The authors asserted that:

One of the often unrecognized ironies attending the work of health personnel is that they who minister to pain also may inflict pain. Indeed, this may be a fairly inevitable part of their jobs . . . It is associated, of course, with a host of essential tasks: diagnosis, surgery, various therapies, regimens, and even the mechanics of giving adequate nursing care. Most of such induced pain is necessary although some of it surely is not. (p. 85)

Publications by Nagy (1994, 1999) and Madjar (1998) followed. Newer publications used different verbiage, including care-related pain, procedural pain, and/or incident pain. At least two different connotations needed to be distinguished: first, CIP as a nurse-patient interaction (also referred to as the co-created situation); and second, the actual infliction of unintended

pain associated with a nursing procedure (broadly defined as some form of physical interaction between a nurse and a patient). Czarnecki et al. (2011) wrote a position statement in which the authors introduced clinical practice recommendations to address procedural pain. Health care institutions could affect nurses' conduct by implementing practice recommendations and by holding nurses accountable.

Clinically Inflicted Pain as a nurse-patient interaction. The sociologists Fagerhaugh and Strauss (1977) framed CIP within the context of nurses' work. The authors identified the following critical issues with regard to CIP: first, the grounds for its legitimation; second, CIP as an implicit staff-patient contract that required cooperation of patients; and third, the division of labor: nurses carried out procedures by following providers' orders and/or by adhering to standards of care. Fagerhaugh and Strauss noted the use of coercion by nurses to ensure the cooperation of patients; the authors viewed the use of coercion as a deviation in nurses' conduct (see also Aveyard, 2002, 2004, and 2005). Issues related to consent were important within the broader context of CIP. For this study, the significance of patients' consent for the experience of nurses was unknown at the time of writing Chapter 2.

Madjar (1998) defined CIP as a "social situation . . . [that] creates its own imperatives" (p. 156). Madjar explained, "It is the nature of the social situation in which it [CIP] occurs, which requires both a therapeutic intent from the person inflicting the pain and active cooperation from the patient, that makes inflicted pain distinctive" (p. 158).

Clinically Inflicted Pain: The unintended pain associated with nursing procedures. The term CIP has been used to refer to the actual infliction of unintended pain.

Two definitions of the term CIP were identified in the nursing literature. Nagy (1994) differentiated between two types of pain:

The first type of pain is the consequence of either the disease itself or of treatment conducted by health professionals other than nurses (e.g., surgical procedures) . . . this type of pain has been termed disorder-induced pain . . . The second type of pain . . . is the consequence of the painful investigative and therapeutic procedures conducted by nurses and is termed clinically inflicted pain. (p. 25)

The exclusion of surgical procedures appears counterintuitive because pain from incision and/or post-surgical pain are “man-made.” Yet, important differences between medical and nursing procedures exist (see Appendix A). In addition, surgical procedures typically are performed by medical providers and therefore fall outside the scope of this study.

Madjar (1998) defined CIP as “any pain experienced by patients that is directly related to procedures or tasks performed on . . . [patients] by hospital personnel” (p. X, Introduction). For the purpose of this study, CIP was broadly defined as unintended pain resulting from any nursing procedure that was linked to physical contact between a nurse and a patient.

Other terminology describing the phenomenon of interest. The phenomenon of unintended pain associated with nursing procedures has been recognized and addressed in the literature under a variety of terms, including procedural pain (Czarnecki et al., 2011; Pasero & McCaffery, 1998; WHO, 2007), care-related pain (Coutaux et al., 2008), and incident pain within palliative care (McQuay & Jadad, 1994; Pallipedia, 2009). Care-related suffering (Sundin, Axelsson, Jansson, & Norberg, 2000) offered yet another dimension and pointed to the perceived failure of nurses to provide emotional support. The term procedural pain (as

opposed to CIP) might capture the aspects of nurses' work more accurately but excludes the interactive quality of CIP and the patient's experience. For the purpose of this study, the terms procedural pain, care-related pain, and incident pain hence were subsumed under the umbrella term CIP.

The role of health care institutions or organizations. I used the verbiage health care institutions and organizations interchangeably. Health care institutions play a role in CIP management. Gibson (1991), who explored the training of people who inflict pain, such as police, soldiers, and "others," coined the term *institutionalized commission of pain*. The World Health Organization (WHO) had a project for institutionalizing pain management pertaining to cancer pain (WHO, 2007). Czarnecki et al. (2011) addressed the issue of procedural pain within the context of a position statement and clinical practice recommendations. Fagerhaugh and Strauss (1977) studied pain management, which included CIP within the context of nurses' work in hospitals and clinics.

Clarke (2009), a so-called second-generation grounded theorist, argued for taking the nonhuman explicitly into account. She wrote that "the human subject is de-centered—no longer the analytic everything" (p. 201). Although I recognized that health care institutions had a role within the context of CIP I did not intend to engage in a situational analysis and remained focused on the human subject (RNs).

Related concepts. I distinguished undermedication and barriers to analgesic administration as distinctly different phenomena. Undermedication (Carr, 2008; Carr & Thomas, 1997; Cohen, 1980; Donovan, Dillon, & McGuire, 1987; Hunter, 2000; Ketovuori, 1987; Oates, Snowdon, & Jayson, 1994) has been defined as the underadministration of ordered analgesic medications—thus constituted an act of omission. Researchers who studied

barriers to analgesic medication administration attempted to identify factors or processes that led to undermedication. I viewed undermedication and barriers to pain management within the broader context of (inadequate) pain management and as such distinctly different from the interactive process or physical interaction that resulted in unintended pain. This study was aimed at infliction of pain, not at pain management.

The decision-making process utilized by nurses appeared to have significance. Wilkinson (2008) explored the psychosocial processes involved in decision-making and reasoning processes of nurses in situations with identified ethical components. Wilkinson utilized the Strauss and Corbin GT method and identified four key processes: being self-aware, determining duties to other/s versus self, engaging self as protector, and restoring self from tension or anguish.

Clinically Inflicted Pain is an empiric phenomenon. CIP is an exceedingly common occurrence as evidenced, for example, by the common nursing procedure of repositioning (turning) a bedbound patient. Repositioning has a number of indisputable benefits (prevention of pressure ulcers, pneumonia, etc.) and is regarded as a procedure intended to comfort the patient. Puntillo et al. (2001) conducted a study looking at the painfulness of nursing (and medical) procedures, such as turning, tracheal suctioning, femoral catheter removal, and non-burn wound dressing changes. A total of 5,957 adult patients at 164 national sites and five international sites participated in this large-scale study. Puntillo et al. found that not only was turning the most painful and distressing procedure for adults but also fewer than 20% of patients received opiates before the procedure. Consistent with these findings, Stanik-Hutt, Soecken, Belcher, Fontaine, and Gift (2001) specifically looked at the turning of trauma patients and found that pain scores increased significantly

with turning (see also Szokol and Vender, 2001). Finley and Schechter (2003) reported that children viewed diagnostic and treatment procedures as far worse than the disease for which they were treated; similar patient responses were reported by Madjar (1998) and Nagy (1999). Coutaux et al. (2008) reported that pain intensity was higher for events that were repeated.

Prevalence of Clinically Inflicted Pain. Coutaux et al. (2008) explored care-related pain in hospitalized patients in acute care departments of two French public hospitals. The authors broadly defined care-related pain as “pain occurring during transportation, movement, diagnostic imaging, physical examination, or treatment ” (p. 3). The authors excluded pain after surgery and included ICU patients on a very limited basis (based on patients’ impaired ability to communicate). The authors reported the prevalence of care-related pain as 55%, or an average of 1.8 events per patient. Eighty-one procedures were identified, and each was categorized in one of eight subgroups: vascular punctures, mobilization, other invasive procedures, nonvascular punctures, treatment, clinical examination, imaging or other diagnostic examination, and other. The most frequently reported pain episodes were vascular punctures (38%) and patient mobilization (24%). Half of these procedures were performed by *nonmedical staff* (nonmedical was not clearly defined but given the context likely included nurses), and 31% took place outside of the patient’s department.

The procedures were classified according to pain intensity, and overall, more than half were rated as severe or extremely severe. The maximum pain intensity was rated higher for events that were repeated. The authors concluded several important points: the study showed an unexpected frequency and diversity of painful procedures; many procedures

considered routine and harmless actually were painful; and procedures that were not directly connected with patient care, such as transportation and waiting periods, were indicated as causing pain. The authors noted that their findings were consistent with another large-scale study completed by Puntillo et al. (2002).

Underrecognition or nonrecognition of Clinically Inflicted Pain. CIP appeared to be either underrecognized (Coutaux et al., 2008; Czarnecki et al., 2011; Madjar, 1998; Nagy, 1994, 1999) or not recognized at all (Czarnecki et al., 2011). This underrecognition or nonrecognition extended beyond nursing. The Joint Commission on Accreditation for Healthcare Organizations (JCAHO) declared an end to excuses for inadequate pain control (Phillips, 2000). Despite this, JCAHO specifically excluded the need for a pain assessment for “service[s], for example . . . being X-rayed” (Joint Commission, 2015, para. 4).

The Patients’ Experience

The experience of CIP for patients was different from the experience of nurses. Fagerhaugh and Strauss (1977) described the difference as the “worked on” as opposed to “workers on” (p. 88). Madjar (1998) provided a good illustration of the difference: “The observed experience involves medical instruments being used to accomplish a necessary task, but the lived experience is [that] of weapons—invading, poking and jabbing . . . the body with no protection and no escape” (p. 154). Madjar postulated that the “wounding nature” distinguished CIP from other pain. Madjar noted that, for patients, CIP meant handing over one’s body, restraining the voice and the body, and facing the effects of illness and/or injury.

Madjar questioned the uniqueness of CIP in a personal email exchange (personal communication, October 15, 2012). Madjar pondered the parallels of CIP to pain inflicted during rituals, in which the endurance of pain was embraced by the person causing the pain

and the person experiencing the pain. This appeared to be an important observation, because it could explain why nurses, despite inflicting pain, outranked other professions in 2010 Gallup's annual Honesty and Ethics survey (Gallup Economy, Dec. 3, 2010).

The Experience of Nurses

The infliction of pain in the process of providing care, although acknowledged, has received either little scholarly attention (Given, 2010; Kornhaber, 2009) or the literature is dated (Kornhaber, 2009). Hirsch (1982) and Sandroff (1983) publically voiced their concerns; similar sentiments were identified in other publications (Kornhaber, 2009; Madjar, 1998; Nagy, 1999). CIP was both problematic and unproblematic for nurses (Kornhaber, 2009; Madjar, 1998; Nagy, 1994, 1999); the experience of nurses who found CIP unproblematic was not known.

Is Clinically Inflicted Pain a stressor for nurses? Nurses on burn units inflict severe pain on a daily basis when conducting baths and dressing changes (considered pillars of burn wound management). I was able to identify one small-scale study, although dated, that examined, among other stressors, the stressfulness of CIP (Lewis, Poppe, Twomey, & Peltier, 1990). Nurses were asked to identify the top 10 stressors, and only 13% identified issues related to pain as one of the greatest stressors, but infliction of pain ranked highest within the category of issues related to pain. In contrast, Madjar (1998) reported a paradoxical situation in which nurses felt unease about the infliction of pain yet also derived satisfaction from the competent performance of procedures.

Nurses' work. Nurses' *work* (italics by Fagerhaugh & Strauss, 1997) was primary to nurses and did not involve dealing with pain; relieving pain was noted to be secondary. The authors isolated four properties that appeared to have significance with regard to CIP. First

were the properties of inflicted pain, which included the predictability, intensity, duration, frequency of occurrence (one-time event versus repeated procedures), and frequency of pain infliction. Second were properties related to nurses' work, which included the degree of technical difficulty, duration until completion, number of people involved in accomplishing the work-task, frequency of occurrence, and the urgency of the work. Third were the properties related to the staff and the patient, which included competence (degree of skill), experience with that particular type of patient, fatigue (fresh versus tired), degree of interest (bored versus challenged) in the work itself and/or the patient, and the level of emotional attachment (i.e., concerned, indifferent versus hostile). Fourth were properties related to organizational structure (ward, clinic), which included workload, urgency of completion, the size and rate of turnover of the staff and the patient populations, the relative proportions of different types of personnel, familiarity of staff with the tasks that incidentally induced pain (newness of procedure, type of patients), working and sentimental relationships among the staff itself based on the experience they had with each other, and the length of time they had worked together, etc.

Personal opinions about Clinically Inflicted Pain. I found two publications that expressed personal opinions about CIP (Hinsch, 1982; Sandroff, 1983). Although dated, I did not see any reason why I should not utilize these publications; in fact, I treated both as primary sources and coded them in order to gain insight into CIP from the nurses' perspective (see Appendix B for coding of parts of the Hinsch publication).

Hinsch (1982) provided a rare personal account about working on a burn unit and having to inflict pain. Hinsch described CIP both as an exception and as a normal occurrence that is perpetual in nature. CIP strained nurses and was potentially reprehensible yet also was

a service and a special duty. CIP required justification (e.g., part of necessary treatment). Nurses went through a process of adjustment and adaptation in order to reconcile the challenges of this special service with the realities of work requirements.

Sandroff (1983) used emotionally charged adjectives to describe CIP, such as “excruciating tasks” (para. 6) and “gruesome job” (para. 7). Sandroff, similar to Hinsch, (1982) described CIP both as an exception and as a daily occurrence. Sandroff noted an imperative for these activities; specifically, nurses did not have a choice in whether to perform these procedures (it was not clear how the mandate was generated). Sandroff acknowledged that nurses “push [patients] beyond their pain limit” (para. 7). Nurses did this knowingly. CIP was described as a threat that fundamentally challenged the nurse on multiple levels, “as a good nurse and a good person and a competent professional” (para. 10). Sandroff did not define what she meant by a good nurse, good person, or competent professional. It was not clear whether the emphasis was placed on good or the object (nurse, person) or on a combination of the two. A possible interpretation of these distinctions could be that the verbiage “good nurse” was referring to the self-image of nurses as care providers and pain alleviators; the verbiage “good person” appeared to extend beyond the professional role to the person who is also a nurse and could be referring to the personal and/or ethical issue of hurting another human being; the verbiage “competent professional” appeared to address professional skill (or lack of skill) in alleviating pain, as the inability to alleviate pain became incompetence.

Sandroff (1983) noted that nurses reacted emotionally and were caught in feelings of “failure-frustration-anger-guilt,” (para. 10) as well as feelings of futility and powerlessness. Blaming patients was one of many reactions utilized by nurses to cope with the infliction of

pain. Being emotionally unaffected was equally unsettling for nurses, and left the nurse doubting her/his emotional integrity. Nurses were left wondering whether they were turning to stone. Yet feeling “too much sympathy and empathy” was perceived as equally counterproductive. Nurses’ emotional reactions affected the quality of their work (“rushing through perfunctory care.” The central question for Sandroff was, “What, then, is the proper equilibrium and how is it achieved?” (1983, para. 12).

The sentiments expressed by Hinsch (1982) and Sandroff (1983) were quite similar: inflicting pain was both the exception and the norm; CIP was an isolated occurrence but was also perpetual in nature. Inflicting pain required justification (or legitimation, as suggested by Fagerhaugh and Strauss, 1977). Once justified, nurses were willing to perform these potentially reprehensible acts and thus effectively break with societal norms of not hurting another human being. Nurses were willing to perform these painful procedures as a (special) service and/or duty; nurses assumed ownership, framed as responsibility. CIP appeared to be a phenomenon in which nurses broke with convention (cultural norms) called for by a higher purpose (helping the patient). Allegorically, this could be viewed as entering the underworld, accomplishing a necessary task, and reemerging transformed (sometimes for the better; other times for the worse). Nurses not only needed to re-enter the world but also needed to repeat the journey.

Inflicting pain triggered typically negative emotions in nurses and challenged nurses on a number of fundamental levels: as a good nurse, as a good person, and as a competent professional. Nurses went through a process of adjustment and adaption and were changed by the experience. I concluded that the experiences of nurses within the context of CIP were complex and contradictory.

Resocialization. Nurses' responses to pain and infliction of pain changed over time (Fagerhaugh & Strauss, 1977; Madjar 1998; Nagy, 1994, 1999). Hinsch (1982) and Sandroff (1983) made references to a process of adjustment and adaption that implied learning. The literature suggested that nurses' responses to pain changed over the course of their careers, particularly during formative periods such as being a nursing student (Allcock & Standen, 1999, 2000), a newly graduated nurse, or when starting in a new specialty area, such as a burn unit (Bernstein, 1976; Madjar, 1998). In addition, peer counseling appeared to shape nurses. I viewed peer counseling as a process that transmitted a nursing discourse. Peer counseling defined how to view and respond to CIP. Sandroff, in particular, went to great lengths to advise nurses on how to find a more balanced approach to CIP.

The psychiatrist Norman Bernstein (1976) had the opportunity to observe and interact with nurses, who cared for burned children, over a period of several years. Bernstein allocated a chapter to Burn Care Personnel and Their Attitudes in his book *Emotional Care of the Facially Burned and Disfigured*. He described the "evolution" of nurses (p. 147) starting work with idealized expectations that quickly transmuted into confrontation and confusion, progressed into ambivalent identification and "realistic" resolution, and finally matured into commitment and acceptance. Bernstein noted that nurses had to overcome "threat[s] to individual identities" (p. 151). He noted that this transformative process typically was completed within one year, a year in which nurses learned new norms, values, beliefs, attitudes, and practices, all of which could be explained by the theory of resocialization. Morrison (2007) wrote:

Resocialization is a process of identity transformation in which people are called upon to learn new roles, while unlearning some aspects of their old ones. . . . This

process often requires an unlearning of internalized norms, values, beliefs, and practices, to be replaced by a new set, which is considered appropriate to the new role. . . . Behaviors and values that were considered normal in ordinary society are seen as deviant and undesirable in the new situation and must be unlearned. In addition, many of the new behaviors and values are considered deviant on “the outside” . . . (para. 1)

Resocialization by itself did not explain the phenomenon of CIP but did explain the transmission of a nursing discourse that, in shaping the nurse, enabled the perpetuation of CIP – or put more simply, *how* nurses continue to function while inflicting pain. Madjar (1998) noted, “Nurses not only disliked inflicting pain and hurting patients in the process of treatment . . . which new nurses had to accept and learn to carry out without being overwhelmed by patients responses” (p. 124). Madjar stated:

There are several factors that help to describe nurses’ experience of being the ones who inflict pain and go on inflicting it: learning to accept the inevitability of pain rather than questioning its necessity in specific situations; learning to see pain as temporary and therefore of less consequence; learning to rationalize about pain and teach oneself not to pay attention to it; learning to think that a nurse is coping with patients’ pain when he/she is able to ignore signs of pain and distress; and learning that technical performance counts more than the amount of pain inflicted or avoided. (p. 125)

I viewed this brief citation as evidence of a nursing discourse and deduced: (a) nurses were conflicted by CIP and/or patients’ responses; (b) CIP was defined as inevitable and temporary, and thus CIP was rife with assumptions; (c) within this nursing discourse, CIP

was to be ignored. This nursing discourse was contradictory to the nurses' image as someone who cares and provides comfort, which was poignantly captured by Wilson-Thomas (1995), who wrote, "Nurses practice in a profession where its philosophy contradicts its action" (p. 571). Price and Cheek (1996) explored the question, "What counts as pain and who decides when someone is in pain?" (p. 899) and proposed that pain and the role of nurses in pain management were discursively constructed.

Adaptive responses to inflicting pain. Nagy (1999) completed a study on strategies used by burns nurses who witness the pain of burns patients, which included, but was not limited to, CIP. Nagy identified four strategies: (a) distancing oneself from the patient's pain (Madjar, 1998, used similar verbiage), (b) engaging with the patient's pain, (c) seeking social support, and (d) reconstructing the core role of nurses.

In Nagy's study, 94% of nurses utilized some form of distancing in order to lessen the impact of inflicted and/or observed pain. Nurses distanced themselves out of fear of being emotionally overwhelmed. Nagy identified five variants in distancing: (a) emotionally detaching oneself by switching off, (b) creating physical distance, (c) focusing on the long-term benefits (away from pain inflicted at that moment), (d) structuring the painful event (maintaining control or a sense of power), and (e) "acting out" negative emotions with families, friends, or colleagues.

Engaging was utilized by 56% of the nurses; nurses focused attention on the patient's pain and made considerable efforts to help control the pain, which seemed to increase the satisfaction that nurses received from their work. Nagy (1999) identified seven strategies in engaging: (1) making efforts to prepare patients for painful experiences, (2) improving one's technical competence and knowledge, (3) sharing control, (4) using all possible pain control

measures, (5) providing emotional comfort to the patient, (6) providing physical comfort, and (7) spending time with patients in non-painful activities.

Seeking social support was utilized by 59% of nurses and was characterized by (a) emotional help, (b) practical help, (c) advice, and (d) social companionship from a variety of sources. Lastly, core role reconstruction was “aimed at reconciling the incompatibility between the nurse’s core image of oneself as a carer whose job involved both relieving pain, and the necessity to cause (at times quite severe) pain to patients” (Nagy, 1999, p. 1431). Core role reconstruction was the least utilized adaptive response (19% of participating nurses).

Infliction of pain appeared to at least trigger some form of a response, most commonly the need to protect the self—or as Nagy (1999) suggested, the identity of the nurse as a carer. It was not clear why nurses engaged in a particular response pattern, how nurses moved from one strategy to another, and whether there was a progression in these responses. It appeared that core role reconstruction increased job satisfaction and/or positive role identification, but it was unknown why this was the least utilized response pattern. Within the discussion part of Nagy’s publication, the issue of guilt was raised but not further elaborated.

Nurses’ assumptions: The redefinition of Clinically Inflicted Pain. CIP was a relatively unexplored aspect of nursing care. I postulated that the paucity of research was linked to widespread and unchallenged assumptions that characterized the nursing discourse related to CIP. While the phenomenon of CIP was an empiric phenomenon, the attributes used to describe the phenomenon and the responses of nurses were riddled with assumptions. I postulated that these assumptions made CIP acceptable to nurses and that these assumptions

hid CIP in plain sight. What follows is a compilation of some of these assumptions (the list was not intended to be complete). CIP was:

- no different from other types of acute pain (Madjar, 1998, p. IX and p. 73);
- inferior to pathologic pain (caused by disease);
- unintended and inevitable: a side effect and justified (Madjar, 1998, pp. VII-VIII);
- predictable in terms of onset, intensity, and duration;
- harmless;
- secondary, short-lived, trivial, and easily managed;
- too transient to be a real concern (Coutaux et al., 2008, p. 6);
- a byproduct (Fagerhaugh & Strauss, 1977, p. 86; Madjar, 1998, p. 17);
- legitimate (Fagerhaugh & Strauss, 1977, p. 86; Madjar, 1998, p. 17);
- necessary (Fagerhaugh & Strauss, 1977, p. 86; Madjar, 1998, p. 17);
- inevitable (Fagerhaugh & Strauss, 1977, p. 85); and
- an important means toward attaining the desired medical end (Fagerhaugh & Strauss, 1977, p. 86).

Nurses also assumed that patients

- became habituated (Madjar, 1998, p. 15);
- got used to the procedures and subsequently had less fear; and
- exaggerated or faked their pain.

Madjar (1998) noted that in an effort to justify and make CIP more acceptable, nurses redefined CIP as instrumental, inevitable, nonharmful, and even beneficial. This redefinition precluded a discussion and/or exploration of CIP. Patients suffered as a result of CIP, and it

was perceivable that CIP could play a role in the development of PTSD, particularly in children and ICU survivors. Yet, it was also important to note that nursing remained a highly trusted profession. I was making the assumption that nurses and patients shared the same objective: getting to the core of the medical problem and remedying the medical condition. It was hoped that the research shed light on these contradictions.

Assumed inevitability of Clinically Inflicted Pain. The assumed inevitability of CIP appeared to be a key assumption about CIP that entrapped nurses. Madjar (1998) wrote:

When nurses perceived everything about inflicting pain as inevitable, they also perceived themselves as unable to change the situation for the better. Rather than seeing themselves as the ones with the knowledge, resources, and the power to relieve and manage pain, nurses felt helpless and immobilized in the face of pain they had inflicted. (p. 134)

Perry (1984), a staff psychiatrist on a burn unit, challenged the notion of the inevitability of CIP and offered a radically different explanation. Perry proposed CIP could possibly fulfill a psychological need for nurses. He drew this conclusion after having made several unsuccessful attempts to improve pain management for burn patients via educational in-services after identifying myths and knowledge deficits related to pain management. In response to these in-services, nurses raised new and different concerns about why more-effective pain management was detrimental. Perry subsequently rephrased the question about pain management: “The question was not why did the staff [referring to nurses] *need* to have the patient hurt, but rather, what was the *fear* of patients’ being pain free?” (p. 310). Perry proposed that the “patient’s pain served two different functions. First, it made the patient a definable being, and second, the pain helped confirm that this ‘object’ was alive” (p. 311).

Perry's question opened me to a new way of viewing CIP, and I rephrased his question:

Could CIP have a purpose for nurses?

Clinically Inflicted Pain had a different meaning for nurses. Madjar (1998) quoted a nurse who showed that CIP had a distinctly different meaning for nurses. The cited example may leave the reader feeling uncomfortable and ready to call this "nursing going astray," yet it captured that pain has meaning for nurses that is unrelated to the essence of pain and the patient's experience.

As the nurse pulled the dressing away from the wound, the patient inhaled deeply and loudly, and then held his breath. Nurse: "Oh, I am glad that's painful. That's good. It's not as deep as I thought it looked. It's a bit hard to tell, especially with the (silver sulphadiazine) cream. It looked a bit white here, but its only cream." Patient: (forcing a nervous laugh) "I am glad it's sore for you!" (The nurse then went on to explain how interested nurses usually are in particular patches of skin they helped to heal or graft.) Nurse: "I'll often ask the patient how 'my' skin is doing because I would have been the one who applied it." Patient: "I wouldn't mind, so long as you remember that I am quite attached to it myself! (p. 121)

In this clinical situation, inflicting pain enabled the nurse to collect important clinical data; as such, inflicting pain helped the nurse accomplish a professional task (to assess the degree of tissue damage) that is unrelated to (but not exclusive of) comforting the patient. This led me to articulate that, in technical terms, patients could be viewed as outcome measures of nurses' work.

Control. The issue of control, within the context of CIP, was raised repeatedly (Fagerhaugh & Strauss, 1977; Madjar, 1998). Control was exercised by nurses through a

variety of means to ensure patients' behavior was conducive to the completion of the task at hand. Nurses utilized a number of different tactics in order to exert control. The question of what motivated nurses to use these tactics appeared to be important for this study.

Fagerhaugh and Strauss (1977) reiterated that the major task was "to get the job done" (p. 91). Fagerhaugh and Strauss further suggested that specific tactics were related to: assessment of the patient; contingencies such as scheduling, how tired the staff was, and the staff's relations with the patient; staff member's style and presence.

Clinically Inflicted Pain: Nurses and the epistemology of pain. Pain has been defined from the experience of the person experiencing pain; pain is a subjective experience. The classic definition of pain was conceived by McCaffery (1968), pain is "whatever the experiencing person says it is, existing whenever the experiencing person says it does" (p. 95). In contrast, nurses have to assess and manage pain and thus have a need to objectify pain, which could lead to questioning the patient's self-report of pain.

J. R. Davitz and L. L. Davitz (1981) explored nurses' behavior, particularly nurses' responses to patients' pain, and proposed that, "the suffering of another person is necessarily inferred rather than directly observed" (p. 11). An inference, as defined by the authors, was based on an observation but also required a cognitive process. The common-sense notion that nurses made inferences about pain and made decisions related to pain assessment and management were noted repeatedly in the literature. I found an abundance of literature addressing pain assessment and management. The literature indicated a continued lack of adequate pain control, even in clinical specialties such as perioperative care and/or burn units (aka burns unit) in which the presence of pain was acknowledged and unchallenged. British researchers Bell and Duffy (2009) conducted a literature review of pain assessment and

management in surgical nursing. The authors reported that an estimated 50% to 75% of patients did not achieve adequate pain relief. Similar results (among other studies) were reported over the past two decades by Apfelbaum, Chen, Mehta, and Gan (2003); Carr (2008); Warfield and Kahn (1995); and by Wells, Pasero, and McCaffery (2008). Zalansky, Chapman, and Meisner (2009) reported that the rate of patients experiencing unrelieved pain has barely changed since the 1950s (see also Carr, 2008). Based on the reviewed literature it appeared as though nurses have a choice in how they approach pain assessment (e.g., a task versus an interaction). Opinions and professional judgments of nurses influence how nurses chose to treat or not treat pain.

There is a schism between nurses and patients, poignantly captured by Scarry (1985): “Pain [is] something that cannot be denied and something that cannot be confirmed . . . to have pain is to have certainty; to hear about pain is to have doubt” (p. 13). Thus, nurses had a fundamentally different epistemological approach to pain. Peter and Watt-Watson (2002) noted that nurses’ distrust of patient reports of pain revealed an epistemic bias that favors objectivity and described this bias as an ethical and epistemological failure (p. 66). I viewed these contradictory pain discourses within the context of the conflicting loyalties of nurses.

Ontological questions about pain and Clinically Inflicted Pain. Nurses not only asked, “Does [the patient] really have any pain? . . . [but] is it ‘real’ or ‘psychological’[pain]?” (Fagerhaugh & Strauss, 1977, p. 24). Madjar (1998) reported that nurses frequently made a distinction between so-called real pain and other uncomfortable and unpleasant sensations that were not defined as pain:

I feel the only real pain that she had was when I took the stitches out; she had very real pain then. I also felt there was a little bit of pain following on the inside of her

calf around the edges of the graft because it is quite superficial, and quite often taking that paranet [paraffin impregnated dressing] off it does sting, so there would have been pain then. But it would not have been great, it just would have been an instant thing . . . She did have a little cry . . . I think it was just a sort of built-up emotion. But other than that, I don't think there was any real pain. (p. 130)

Madjar (1998) further reported that nurses interpreted vocal or other indications of pain as signs of anxiety, fear, and even hysteria. Summer, Puntillo, Miaskowski, Green, and Levine (2007) reported that procedural pain associated with burn care frequently produced significant anxiety and distress and that anxiety increased over time in burn-injured patients. It was interesting to note that Summer et al. reported no significant advances had been accomplished in clinical practice in the pain management of burn-injured patients during the last 20 years. It appeared that there was a correlation between pain and anxiety, and/or distress. But anxiety and/or distress were also unrelated to pain. It appeared as though nurses perceived *something* when interacting with patients in pain. It was not clear whether nurses observed the psychological reactions as noted above or whether nurses projected their inferences onto patients in an attempt to justify their conduct as they continued to inflict pain.

The nurses' perception of *something* raised the question of suffering. Cassell (1983) reported, "suffering occurs . . . when the illness or its symptoms threaten not only interference with some aspect of [the] person – virtually any illness does that - but when it destroys or is perceived to destroy the integrity of the person through its effects" (p. 522). Sundin, Axelsson, Jansson, and Norberg (2000) and Arman, Rehnsfeldt, Lindholm, Hamrin, and Eriksson (2004) researched suffering related to care. Arman et al. defined suffering related to care as "basically a matter of neglect and uncaring where the patient's existential

suffering is not seen and she [the patient] is not viewed as a whole human being” (2004, p. 248).

Models to Explain the Ability to Inflict Pain

The question arose, What made nurses carry out painful procedures? There were, of course, the obvious answers: following providers’ orders, adhering to standards of care, or simply wanting to help. It was not known how nurses overcame presumed psychological barriers to inflict pain. Gibson’s (1991) work led me to explore the following theoretical models: Milgram’s (1963) study on obedience, Bandura’s (1990) mechanism of moral disengagement, and Altemeyer’s (1988, 2004) model of highly dominating, authoritarian personalities. I anticipated that studying these theoretical models could provide important insights, leads or questions with regard to CIP.

Milgram’s study of obedience. In 1963 Milgram conducted a behavioral study of obedience. In it, subjects were led to believe that they were to administer electric shocks to a “student” (a trained confederate of the experimenter) in order to study the effects of punishment on memory. The instrument for shock delivery bore visual designations ranging from “Slight Shock” to “Danger: Severe Shock.” The student pretended to react to these shocks via a standardized protocol. The naïve subject was “ordered” by a physically present “experimenter” to administer increasingly more intense shocks to the victim, even to the point of reaching the level marked “Danger.” The point of rapture was the act of disobedience. Milgram was surprised by two findings: the number of obedient subjects and the extraordinary tension generated by the procedure, thought to be due to following orders and administering shocks. Milgram noted that the persons delivering the shocks acted against their own values, expressed deep disapproval, and even denounced shocking as stupid and

senseless. Yet the majority of participants complied with the commands despite having nothing to risk or lose by disobeying orders. Milgram noted that obedience is a “basic . . . element in the structure of social life . . . [it is a] psychological mechanism that links individual action to a . . . purpose . . . [obedience is a] prepotent impulse overriding training in ethics, sympathy, and moral conduct” (p. 371).

Gibson (1991) critiqued the so-called Milgram experiment as possibly explaining short-term obedience to authority under laboratory conditions; it was not known whether individuals would be as likely to administer shocks if not ordered by an authority. Milgram’s theory failed to explain the extraordinary tension felt by the study participants while following orders and why this tension did not stop them.

Bandura’s social cognitive theory: Mechanisms of moral disengagement.

Bandura (1990, n.d.; Bandura, Barbaranelli, Caprara, & Pastorelli 1996; Bandura, Underwood, & Fromson, 1975) distinguished between moral thoughts (i.e., moral standards) as opposed to moral conduct. Bandura suggested that moral standards were developed through the process of socialization and served as guides and deterrents for conduct. Once learned, people regulated their actions by sanctions they applied to themselves. Bandura noted that these self-regulatory mechanisms needed to be activated and, in addition, that moral reactions could be disengaged by a number of psychological processes. Bandura challenged the notion that moral disengagement occurred only under extraordinary circumstances: “Quite the contrary. Such mechanisms operate in everyday situations in which decent people routinely perform activities that . . . have injurious human effects” (Bandura, 1990, p. 2). Osofsky, Bandura, and Zimbardo (2005) further noted that personal disengagement was not an entirely personal matter. People were enmeshed in social roles and

functions that required inflicting harm on others (police, military personal, and corrections officer). Osofsky et al. quoted an execution team participant: “You have to be compassionate or else you can’t perform your work” (2005, p. 376), and “We have a job to do, and that job isn’t to be a coldhearted individual” (2005, p. 385).

Osofsky et al. (2005) identified three sets of psychological mechanisms that fostered moral disengagement. The first set consisted of moral justification (i.e., worthy ends are used to vindicate injurious means); the use of euphemistic language in which injurious behavior is rendered benign; and/or the use of exonerative comparison, the “cloaking [of] injurious behavior in an aura of benevolence” (Osofsky et al., 2005, p. 373). The second set consisted of displacement of responsibility, in which people viewed their actions as stemming from the dictates of authorities (as opposed to personal responsibility); and diffusion of responsibility via division of labor, group decision-making, and engaging in collective action. The third and final set of disengagement mechanisms consisted of dehumanizing and blaming the recipient.

The work of Osofsky et al. (2005) appeared to be pertinent to the question of CIP in a number of ways. While Osofsky et al. addressed the institutionalized and lawful infliction of “harm” (executions), the authors introduced additional features that appeared to have significance for CIP: desensitization through routinization; the (emotional) reaction (i.e., response to the desensitization); the sense of duty and professionalism; situational role demands; the gradual process of transformation; the sense of dignity; and challenges associated with thought suppression, etc.

Altemeyer’s model of personality characteristics. Altemeyer (1988, 2004), within the context of right-wing authoritarianisms, asked why some people succumb to pressures

from an authority more readily than others and engage in aggressive behaviors. Altemeyer (1988) defined aggressivity as:

a predisposition to cause harm to someone. The harm can be physical injury, psychological suffering, financial loss, social isolation, or some other negative state. Aggressiveness is authoritarian when it is accompanied by the belief that established authority approves it or that it will help preserve established authority. (p. 4)

Altemeyer (1988) isolated attitudinal clusters constituting a personality and proposed a correlation of certain personality profiles and their proclivity to aggression. The three attitudinal clusters were (a) authoritarian submission, defined as a high degree of submission to the authorities who were perceived to be established and legitimate; (b) authoritarian aggression, defined as a general aggressiveness directed against various persons that was perceived to be sanctioned by established authorities; and (c) conventionalism, defined as a high degree of adherence to the social conventions perceived to be endorsed by society and its established authorities. Altemeyer (1988) happened to study nursing students (in addition to liberal arts and administrative studies majors) and noted that nursing students scored higher on the measurement tool (the right-wing authoritarianism scale) when compared to liberal arts or administrative majors.

Clinically Inflicted Pain Within the Framework of Ethics and/or Morals

It was not known whether nurses perceived CIP as an ethical or moral question. CIP was disconcerting to some nurses; nurses appeared to draw a line somewhere. Nagy (1994) listed a number of circumstances in which nurses questioned inflicting pain: when patients refused treatment or faced poor quality of life, when there was a poor chance of survival, when procedures were deemed unnecessary, and if nurses projected that patients would

discontinue treatment after discharge. Nurses appeared to have a need to justify inflicting pain. Nurses appeared not to condemn CIP itself as ethically difficult or morally wrong, except within the context of perceived medical futility, at which point nurses associated CIP with torture. It appeared as though nurses struck some kind of bargain and were willing to carry out painful procedures, if they perceived a benefit, such as the possibility of a positive outcome. I did not know whether an ethical or moral framework could explain CIP.

A preliminary literature review was conducted with regard to ethics and morals. The nursing literature was inundated with definitions and distinctions. Ethics and morals were defined, within the context of personal conduct and/or virtue, as a cultural issue (Jameton, 1990) and as a professional issue (Garity, 2005). Among the many issues raised by nurses ethical-moral reasoning and ethical-moral development appeared to possibly bear significance for the study (Omery, Henneman, Billet, Luna-Raines, & Brown-Saltzman, 1995).

It was not known at the time of writing chapter 2 whether nurses would describe CIP as an ethical or moral question. Other questions arose such as: What constitutes an ethical and/or moral dilemma? How do nurses define ethics, i.e., morals, within the context of CIP? Are ethics and morals the same, and if not, how are these entities different? And further, what distinguishes a moral issue from a personal issue, a situational issue or an organization/system-based issue, such as the hierarchy of decision-making, a lack of resources, etc. (McCarthy & Deady, 2008).

I deliberately did not attempt to answer these questions at the time of writing Chapter 2 and viewed these questions as potentially sensitizing concepts; a premature definition could have amounted to a preconceived idea (i.e., forcing the data as opposed to discovering

emerging concepts). I did familiarize myself with some of the literature, and it appeared as though infliction of pain might fit the framework of an ethical or moral dilemma. Inflicting pain appeared to be problematic (a) within the context of medical futility, (b) when there is disagreement between the ordering provider and the nurse, (c) when consent could not be given, and/or (d) the patient resisted care. An observation was called for: Nurses did not view CIP as problematic per se, but the surrounding circumstances defined the level of conflict. While ethics or morals could provide a framework, it was not clear whether the ethical or moral framework could explain the behavior of nurses.

Principle of the Double Effect (aka Standard Doctrine of the Double Effect)

In the review of literature on ethics, I noted the principle (or doctrine) of the double effect, commonly utilized in palliative and hospice care. The principle of the double effect is the process of providing effective pain management to a terminally ill patient, in which potentially lethal doses of an analgesic medication are ordered and administered. Nuccetelli and Seay (2000) described it as:

The standard . . . [by which] an action with good and bad effects may nevertheless be morally justified, provided that *only the good effect is intended* [italics by Nuccetelli and Seay] and the bad effects were merely foreseen. The bad action needed to be morally permissible, i.e., bad results were a means to the good end, and that the good achieved thereby is great enough to outweigh the bad. (p.19)

Nuccetelli and Seay based their argument on a plausible moral intuition: “There is a morally relevant difference between bringing about foreseen, unintended, unavoidable harms while pursuing something good, and bringing them about as a *means* to that good” (p. 19).

Nuccetelli and Seay noted that the question of culpability (and/or blame) was a different question. The principle of the double effect appeared somewhat fitting for CIP.

The Question of Violence, Aggression, and/or Torture

The question of violence was raised in the German discussion about Gewalt in der Pflege, which I translated to mean violence in nursing. The German discourse differentiated between physical, psychological, and structural violence. Violence was perceived and defined differently from the perspective of nurses as opposed to patients and/or Angehörigen (a group of people involved with a patient; a broader concept than family). Gewalt (violence) was defined as: “eine Handlung, ein Nicht-handeln oder eine Drohung . . . die grundlegende menschliche Bedürfnisse (Wohlbefinden, Überleben, persönliche Identität und Freiheit) beeinträchtigt, einschränkt oder deren Befriedigung verhindert” (Deutsche Alzheimer Gesellschaft, 2002) – translated to mean: violence is an act, the omission of an act, or a threat that interferes, limits, or prohibits the satisfaction of basic human needs, such as well-being, survival, personal identity, or freedom.

CIP has been associated with violence and aggression (Dind, 1989). I explored various definitions; violence and aggression are complex concepts. Fromm (1973) captured some of, what he calls, the confusion surrounding aggression:

The term has been applied to the behavior of a man defending his life against attack, a robber killing his victim in order to obtain money, to a sadist torturing a prisoner. The confusion goes even further: The term has been used for the sexual approach of the male to the female, to the forward-driving impulses of a mountain climber or a salesman, and to the peasant plowing the earth. (p. 19)

Bandura et al. (1996) cautioned that “psychological theorizing and research on aggression has focused heavily on impulse aggression . . . [yet] much reprehensible and destructive conduct has been perpetrated by ordinary, otherwise considerate people on grounds of religious principles, righteous ideologies, nationalistic imperatives, and ruthless social policies” (p. 372)—in everyday situations (Bandura, 1990).

Nurses, themselves, described their conduct as cruel; Madjar (1998) reported that nurses, after encountering patients resisting care, were “feeling upright, not nice, or cruel” (p. 122) or as cited by Nagy (1994), “I feel awful about it. . . it’s horrific to have to hurt them . . . It’s the worst part of the job . . . you’re always having to do something cruel” (pp. 140-141). References to torture were found in the literature (Daly, 1978; Dind, 1989; Dyer, 1995; Laborde, 1989; Schroeder, 1992). Dind (1989) equated some medically necessary procedures (e.g., obtaining blood samples for diagnostic testing) with violence and aggressivity—the same violence, she noted, was also seen when torture was applied. Dind argued that CIP was differentiated from torture by the therapeutic intent of nurses carrying out procedures. Schroeder (1992) also discussed CIP within the context of torture. Schroeder noted that nurses severed the relationship with patients (e.g., objectified the patient). Nurses disembodied, generated a distance, and thus shielded themselves from the emotional experience of inflicting pain. CIP and torture, Schroeder noted, were also different in a number of ways. To Schroeder, torture, in contrast to CIP, intended to cause pain, whereas CIP was an unintended byproduct. Schroeder argued that both nurses and torturers claimed inflicting pain was done to “do good” (1992, p. 215). The association with torture was also drawn within the context of futility of care (Heland, 2006).

I have been disturbed by the fact that many children and ICU survivors developed PTSD as a result of their hospitalization. I did not know whether there was a connection between the nurses' report of violence or aggression and PTSD in patients. The terms violence and aggression typically have been used within the context of criminal activity. I did not intend to equate care with criminal activity.

Closing Remarks

Within the context of pain associated with nursing procedures, three components needed to be differentiated: CIP, the shared experience between a nurse and a patient; the patients' experience; and the nurses' experience. It appeared as though CIP was both problematic and unproblematic to nurses; it was not known what constituted the difference. I viewed CIP as an empiric phenomenon that was common and characterized by a number of assumptions. It was further characterized by underrecognition or nonrecognition. It appeared that CIP was a learned behavior and was transmitted via an unwritten nursing discourse through processes that could be captured as resocialization of nurses. It was not known how nurses were changed as the result of having to inflict pain and how this change affected the conduct of nurses and the care they provided. CIP challenged core assumptions within nursing with regard to epistemology and ontology of pain—as well as the discipline of nursing. Nurses associated CIP with violence, aggression, and torture. The role of health care organizations, or the institutionalized commission of pain, has not been explored but could prove to be an important factor in legal and professional accountability of nurses.

Chapter 3 Methodology

The purpose of this study was to explore the experiences of nurses who, in the process of providing care, inflicted unintended pain. Despite empirical evidence that clinically inflicted pain (CIP) was a widespread and frequent occurrence, little was known about the experience of nurses. When I began this study I did not know whether the term CIP captured the phenomenon of interest; it appeared possible that framing the nurses' experience in the context of CIP could be misplaced or misleading. I anticipated the possibility that different terminology could emerge.

J. Averill (personal communication, September 12, 2013) pointed out that typically a first step in innovative studies consists of “exploring and asking and describing [and] eventually we may be able to explain, predict, generalize or manage/control.” Grounded theory (GT), with its emphasis on examining processes and the explicit aim of creating abstract theory of the data, appeared to be the most fitting method. The relatively small scale of my study as well as many alternative explanations and variables posing as possible extraneous factors were a concern. One committee member noted that many GT studies often did not reach the level of theoretical explanation of the phenomenon of interest. I address these concerns in subsequent sections of this chapter.

This chapter begins with an explanation of why I chose GT, and then I introduce critical issues within GT, including forcing and theoretical sensitivity. Next I address the issue of the literature review and my intimate knowledge of the substantive field. Then I situate grounded theory and follow it with a discussion of the research design and interpretative paradigm; methodological controversies are delineated. I provide a brief introduction of GT methodology: situating GT and explaining procedures with regard to data

analysis. Data analysis is divided into three sections: (a) coding and comparative analysis, (b) memoing, and (c) the final stages: sorting, writing, and the literature review. I address issues related to data collection, the sample, sampling methods, sample size, and briefly discuss entering the field and audio recording. I address ethical considerations and human subjects, criteria used to evaluate GT, and limitations of the study. I included the demographic data collected in this study.

Rationale for Choosing a Grounded-Theory Approach for This Study

This study, within a qualitative framework, was suited for grounded theory (GT) because GT is a general inductive method that is grounded in empirical data, with the explicit aim to generate a theoretical understanding of the phenomenon of interest. Although GT typically is viewed and defined as an inductive method, GT utilizes deductive processes, described by Glaser (1978) as deductive elaborating. Deductive processes are vital to the theoretical sampling phase of GT. Glaser differentiated between “conceptual elaborating as opposed to the logical elaboration founded in deductive hypotheses testing research” (1978, p. 37). Glaser explained,

Deductive work in GT is used to derive from induced codes conceptual guides [italics by Glaser] as to where to go next for which comparative group or subgroup, in order to sample for more data to generate theory . . . Deduction is in the service of further induction and the source of derivations are the codes generating from comparing data, not deductions from pre-existing theories in the extant literature. (pp. 37-38)

In accordance with GT, I assumed that the behavior of people (nurses in this setting) is not random and indicates a pattern that can be explained (theorized). Holton (2012a) explained, “The conceptualization of this main concern and the multivariate responses to this

continual resolution emerge as a latent pattern of social behavior that forms the basis for the articulation of a grounded theory” (p. 221). GT intends to build a theoretical understanding of these patterns and aims to discover theory (i.e., an explanatory model that is useful to participants).

Critical Issues Within Grounded Theory: Forcing and Theoretical Sensitivity

Within the GT methodology, forcing is understood to be any theoretical understanding, any question, even the collection of so-called “face sheet data” (demographic data). The concern is that forcing may lead to neglecting or even abolishing relevant theoretical explanations, concepts, and hypotheses, thus obscuring the emerging theory (Krieger, 2011). In this study, the threat of forcing was compounded by my intimate knowledge of the field. Moore (2012) published a thought-provoking paper on positionality, in which she discussed the intricacies (blurring) of the mixed insider/outsider perspective when researchers are part of the social group they are studying.

Literature Review

Traditionally, a literature review is completed prior to the beginning of a study to ascertain gaps, to test hypotheses, to formulate research questions, and to contribute ideas. In contrast, “In GT there is no need to review the [substantive] literature” (Glaser, 1992, p. 31) prior to the onset of a study. The substantive literature review is typically postponed until a theory emerges, primarily because the theory is not known at the beginning of the study.

Glaser (2001) cautioned that a premature literature review could:

1. forc[e the researcher] into descriptive capture,
2. strangle and paralyze generative conceptualization,
3. force preconceptive entrapment,
4. fill the candidate with normative ‘oughts’ that are not relevant to the emergent problem and
5. even in

correcting may be very hard to disengage from because of preempting conceptual thoughts or preconceived entrapment. (pp. 139-140)

Glaser encouraged the researcher to read outside the substantive discipline, which he referred to as “reading for ideas” (1992, p. 34). Ideas, according to Glaser, increase theoretical sensitivity (i.e., the ability of the researcher to conceptualize). In GT the literature review in the substantive field will commence once a theory is sufficiently grounded in a core variable (Glaser, 2001). The literature review at that point is relevant to the emerging theory and (a) may serve to inform and/or guide the generation of memos, (b) will inform and relate substantive theory to relevant (i.e., discovered) theory, (c) will add the contributions of other researchers, and (d) may refine the emerging theory in the context of extant knowledge or raise the level of conceptualization from substantive to formal theory.

For this study, a preliminary substantive literature review was completed to learn about the contributions of other researchers, to gain insight into what was known about CIP, and to fulfill the requirements imposed by the University of New Mexico. From the literature review, several things were learned: (a) the paucity of literature revealed the apparent gaps in knowledge; (b) CIP adversely affected some but not all nurses; it was not known what accounted for the difference; (c) responses to inflicted pain appeared to be learned; (d) a nursing discourse informed nurses about CIP; (e) there was little or no professional, organizational, or ethical guidance with regard to nurses’ conduct; and (f) exploring CIP illuminated a shadow side of nursing and placed nursing care in the context of violence and torture. It was obvious that I did not enter this research as a *tabula rasa*. I was influenced by the (a) initial literature review, (b) my intimate knowledge of the substantive field, and (c) the personal question I had raised and my own life experiences. I recognized that

professional experience is different from theoretical sensitivity. Glaser (1978) wrote *Theoretical Sensitivity* after identifying theoretical sensitivity as a major gap in *Discovery of Theory* (1967/2009). Glaser (1992) defined theoretical sensitivity as the “researcher’s knowledge, understanding and skill, which foster his generation of categories and properties and increase his ability to relate them into hypotheses, and to further integrate the hypotheses, according to emergent theoretical codes” (p. 27). Glaser cautioned:

A researcher may be very sensitive to his personal experience, his area in general and his data specifically, but if he does not have theoretical sensitivity . . . his results will be a combination of empirical description with some preconceived conceptual description. (1992, p. 27).

For Glaser, theoretical sensitivity is an analytic capacity of the researcher.

The literature review and my intimate knowledge of the field not only sensitized me to CIP but also obstructed my efforts to break out of the framework of a professional problem, or more simply put, of what was known. The framework of a professional problem or concept highlights the constraints of a preconceived notion. CIP within nursing is a well-known phenomenon, and its assumed inevitability could preclude further exploration or could reduce CIP to a procedural issue that can be remedied via policies and procedures. Framing the issue outside of a professional context (e.g., “teaching people to be cruel”) opened avenues that go beyond the professional framing of the phenomenon of interest. It was exceedingly difficult to view the nurses’ experience as a separate phenomenon and independent from the experience of patients. It was my hope and belief that my knowledge of the discipline would enable me to probe deeper into the hidden aspects of CIP and to go beyond full conceptual description. Glaser (1992) articulated the term full conceptual

description to distinguish his understanding of GT from that of Strauss and Corbin (1990); Glaser viewed the GT proposed by Strauss and Corbin as a valid but distinctly different method.

The question then arose: How did I intend to manage these preconceived ideas and guard against bias (forcing)? I safeguarded this research foremost by making my perspective explicit. I also fostered self-awareness by reflecting on data through personal-response documentation in the form of reflective journaling in a separate and parallel document. Relevant insights were captured in the form of a memo (defined as theoretical write-ups) and were correlated with data. Engaging in constant comparative analysis was another safeguard during all stages of the analysis. I suspended further substantive literature review until a theory was developed. Lastly, I engaged in peer counseling (a.k.a. debriefing) to identify ungrounded assumptions.

Situating Grounded Theory

GT was introduced in 1967 by Barney Glaser and Anselm Strauss with the publication of *The Discovery of Grounded Theory*. The 1990 publication by Anselm Strauss and Juliet Corbin of *Basics in Qualitative Research* (1990) indicated a split between the founders. GT has since branched into different factions: Glaser (Glaserian GT, a.k.a. classic GT; Strauss and Corbin; Charmaz (constructivist GT); Clarke (situational analysis); and Bowers (dimensional analysis). GT has been utilized in a variety of disciplines, including nursing.

Theoretical Paradigm

The use of an *a priori* theoretical framework is a contentious issue for Glaser. Glaser (2003) rejected any interpretive paradigm on the ontological, epistemological, and

methodological level. Glaser (2005b) characterized GT as a relatively simple inductive model that can be used on any data type and with any theoretical perspective. Glaser (2003) rejected the use of any *a priori* theoretical framework and the notion of theoretical coherence as a scholarly way of logical conjecture and thus as a potential threat to the method. Glaser argued that the abstract nature of GT, which generates concepts, only applies for explanations, not truth(s) based on facts. Concepts, Glaser argued, are integrated, interrelated categories with highly applicable properties but are not factual; specifically, concepts explain but do not describe. Glaser further argued that GT is different by its modifiable nature, most notable that GT constantly verifies and modifies concepts and their relationship (2003, p. 182).

To understand Glaser's stance, the distinction between evidence and facts needs to be illuminated. Glaser and Strauss (1967/2009), in the *Discovery of Grounded Theory*, explained that evidence is not synonymous with facts, although evidence can be constituted by facts. Facts within a research context typically are viewed in terms of accuracy and generality. In GT, facts are viewed as indicators for the concept; concepts are defined here as a theoretical abstraction. Facts within the GT framework are not required to be accurate. Glaser and Strauss found that "in generating theory it is not the fact upon which we stand but the conceptual category (or conceptual property of the category) that was generated from it" (1967/2009, p. 23). Concepts do not change; facts do. Generality of a fact (structural boundaries) is of greater significance for GT; in fact, GT subsumes establishing generalizations, for "generalizations not only help delimit the grounded theory's boundaries of applicability; more important ... they help broaden the theory ... and ha[ve] greater explanatory and predictive power" (1967/2009, p. 24). Glaser and Strauss (citing Kuhn)

reported that “evidence and testing never destroy a theory (of any generality), they only modify it” (1967/2009, p. 28). Christiansen (2007), in an attempt to assert Glaser’s position, wrote:

Due to its rationale, the classic GT methodology is almost free of logically derived assumptions regarding ontology and epistemology. Its basic assumptions are limited to this: Because man is a meaning-making creature, social life is patterned and empirically integrated. It is only a question of applying a rigorous and systematic method for discovering and explaining these patterns. (p. 44)

Glaser acknowledged, during the 2013 Mill Valley seminar, that “meaning making” was adopted from symbolic interactionism but rejected the idea of symbolic interactionism as an underlying theoretical framework. Holton (2012a) made similar assertions. Christiansen’s synopsis was in fact a statement of ontological assumptions, and thus I rejected the notion that GT is free of epistemological and ontological assumptions. Similarly, Charmaz (1994) noted one of the major problems with Glaserian GT was its:

glossing over its epistemological assumptions . . . [and explained that] the relation between subjectivist and objectivist realities and levels of explanation remain unspecified . . . [and pointed out that the] grounded theorists use [of] their prior theoretical perspectives remain somewhat ambiguous. (p. 73)

I believe that Glaserian GT is rooted in the positivistic tradition and that positivism has remained to be GT’s basic premise. Specifically, GT assumes an external world about which an unbiased observer can discover abstract generalities and explain empirical phenomena. The following objectivist patterns are noted: GT assumes that (a) there is an external reality, (b) data will be discovered, (c) conceptualizations emerge from data, (d)

representation of data is unproblematic, and (e) neutrality, passivity, and authority of the researcher. GT aims to achieve (a) context-free generalizations, (b) parsimonious abstract conceptualization that transcends historical and situational locations, (c) specific variables, and (d) the creation of theory that fits, works, has relevance, and is modifiable (Charmaz, 2009). Simmons (2011) objected when he wrote, “Unlike objectivism, classic grounded theory is not about discovering an obdurate, objective reality independent of subjective realities; it is about discovering, conceptualizing, and explaining patterned subjective realities, with full recognition that meanings are continuous, emergent social constructions” (p. 25). Yet, Simmons equally rejected the notion that GT is constructivist. I believe that GT clearly has positivistic roots and that GT is an evolving methodology and that ontological and epistemological questions need to be ousted and resolved.

Other Ph.D. candidates solved Glaser’s rejection of a research paradigm by retroactively applying a theoretical model once a theory emerged (Elliot & Higgins, 2012). Holton (2012a) argued that although classic GT is not free of any theoretical lens, the researcher could adopt any ontological stance and any epistemological perspective appropriate to the data. I intended to follow the procedures outlined by Glaser and remained in the objectivist tradition of GT in analyzing the data and drawing theoretical conclusions. Given that I was a novice researcher, I incorporated more-conventional procedural steps, as recommended by my committee. The noted deviations from classic GT did not prevent me from staying true to the method. Given that I knew little about the possible findings and the discovered theory of the study it was difficult to pigeonhole a theoretical framework.

Research Design

I studied the real-world situation of nurses inflicting unintended pain as part of common nursing procedures. Interviews were the primary means of data collection. Given the paucity of research, the research question was purposefully stated broadly; I developed an initial questionnaire, and given the emergent design, I modified my questions as concepts began to emerge. It was impossible and inappropriate when writing Chapter 3 to specify operational variables, state hypotheses, or finalize sampling schemes. Given the constraints of a dissertation, I did not anticipate deviating from the proposed setting. I followed interests, leads, and hunches (theoretical hypotheses) based on the data, and I redirected the research accordingly in order to discover a core variable, create theoretical categories from the data, analyze relationships between key categories, and thus articulate a theory from the data.

I approached the field with empathic neutrality. Neutrality was understood to mean refraining from taking a particular perspective or manipulating the data to arrive at predisposed truths. I reported honest, meaningful, credible, and empirically supported findings (Patton, 2002) and theorized these findings. I accomplished this by generating an audit trail (Rodgers & Cowles, 1993), writing memos, and discussing findings with others (peer counseling). These strategies stimulated reflection and feedback.

Data Analysis

This section provides a brief overview of GT methodology and methods and how I applied GT methodology and methods to this study. This section focuses on data analysis because data collection is addressed in more detail in the sampling section of this chapter. The section on data analysis is divided into (a) coding and constant comparative, (b) memoing, and the (c) the final stages of sorting, writing, and literature review.

Coding and constant comparative analysis. Holton (2012b) described coding as the core process in GT methodology; coding accomplishes conceptual abstraction of data (not mere summaries or descriptions) and its reintegration as theory. Coding is divided into (a) substantive coding, which includes both open and selective coding, followed by (b) theoretical coding. The process of constant comparative analysis (the comparison of incident with incident and of incident with concept is initiated concurrently with substantive coding and continues through the research process to facilitate conceptualization [i.e., emergence of categories and their properties]). The process is best characterized as “relating data to ideas, then ideas to other ideas” (Simmons, 2009).

Substantive coding. No particular rules guide the process of coding. Glaser (1978) advised to “cod(e) the data in everyway possible” (p. 56). Coding begins with substantive coding comprised of open and selective coding. During substantive coding, the researcher works with the data directly, a process described by Holton (2012b) as fracturing and analyzing the data in order to find the core category and related concepts. Concept was defined by Glaser (1992) as “the underlying, meaning, uniformity and/or pattern within a set of descriptive incidents” (p. 38). Open coding ceases when a core category and related concepts emerge, at which point selective coding (and theoretical sampling) is initiated. This process is repeated until theoretical saturation is reached (defined as the point at which no new data are emerging). Selective coding serves to saturate the core category and related concepts.

Core category (or variable). Christiansen (2007) explained that a core variable (or category) could be viewed as “stable latent patterns that summarize the empirical substance of the data and signify the underlying meaning, uniformity and/or pattern” (p. 47). A core

variable accounts for the most variation in the data and to which almost everything relates. GT can be viewed as a theory that explains a discovered core variable. Fitting names are applied to each pattern. Simmons (2010) noted that concepts should have imagery, grab, and fit.

Theoretical saturation and theoretical coding. Theoretical saturation is achieved through coding and comparative analysis. Theoretical saturation is reached when no new properties or dimensions are emerging from continued coding and comparison; theoretical saturation marks the beginning of theoretical coding. In a more recent publication, Holton (2012b) defined saturation within the context of interchangeability of indicators.

The interchangeability of indicators is one of the roots of GT. Glaser (2005a) credited Paul F. Lazarsfeld with “four important methodological beginnings. First, the index formation model based on accumulation and summing of indicators from survey data to generate indexes or concepts . . . Second, Lazarsfeld model of interchangeability of indicators and Glaser’s idea of theoretical saturation” (p. 4). Third, Glaser added the constant comparative analysis approach. Last, Lazarsfeld and Thielens (1958) demonstrated that the core variable analysis model has great yield (see also Glaser, 2005b). Glaser (2005a) explained that GT is

based in a concept-indicator model leading to conceptualization taken from psychological research and used extensively in quantitative research. I [Glaser] then added the constant comparative method – comparing indicators – to conceptualize the categories and their properties. . . then added Lazarsfeld’s notion of the interchangeability of indicators, which led to theoretical saturation . . . thus GT came straight from survey research analysis . . . GT is a relatively simple inductive model

that can be used on any data type and with any theoretical perspective. It is just a general inductive model, or paradigm . . . that is sufficiently general to be used at will by any researcher in any field, any department and any data type. No one theoretical perspective can possess it. (p. 144)

When theoretical saturation has been reached, the researcher

shifts attention to exploring the emergent fit of theoretical codes that enable the conceptual integration of the core and related concepts to produce hypotheses that account for relationships between the concepts and thereby explaining the latent pattern of social behavior that form the basis of the emerging theory. (Holton, 2012b, p. 275)

Theoretical codes were defined by Glaser (1978) as “the essential relationship between data and theory” (p. 55). Glaser explained, “Theoretical codes implicitly conceptualize how the substantive codes will relate to each other as interrelated, multivariate hypotheses in accounting for resolving the main concern” (1998, p. 163).

Given the purpose of this study and the limits imposed by a dissertation, it appeared appropriate to stipulate parameters and anticipate steps in order to make my thought process more transparent for the reader. I was hesitant to impose limitations for a number of reasons. The main reason was my awareness that the concept of CIP is likely a misleading framework that might not capture the experience of nurses. As I delved deeper into CIP, a very different story began to emerge, a story that was triggered by CIP but did not capture how nurses viewed CIP. It was a story of the self-sacrifice of nurses (breaking with the basic moral conduct of not hurting another human being) to serve something of a higher order (facilitating a patient’s healing) and by inflicting pain, entering the “underworld” (breaking

with societal taboos, unleashing the dark within), and re-emerging into the world just to have to inflict pain again and again. However, I concurred with the idea of imposing limitations and ensuring transparency, and I remained within the confines of this study. Future research could explore the experience of police officers and soldiers and compare their experience to that of nurses.

When using GT methods in the initial research phase, selected sites, sampling, and data collection (interviewing) can be defined more narrowly, yet subsequent phases are dependent on the emergent theory. I remained within the same settings, stuck to the same population (nurses), and utilized the same method of data collection (interviewing), which resulted in a theory pertinent to nursing.

Memoing. Glaser (1998) referred to memoing as preconscious processing that comes to fruition (in memos). Memoing (the writing of memos) is not identical to field notes, which Glaser viewed as data. Memoing was described by Glaser as theorizing write-ups of ideas about concepts and their relationships, particularly as they relate to the core variable; as such, memos are distinctly different from field notes. Memoing is conceptual-ideational, not descriptive. Memo writing in GT is a continuous process and supersedes all other research activities. The process of sorting memos is important throughout but is crucial in the later stages of the theoretical write-up.

Glaser (1978) recommended separating memos from data, and data from memos, and I followed Glaser's recommendations. Memos can be and should be modified as indicated. Glaser (1978) made a number of practical suggestions that I intended to observe: (a) keep a list of emergent codes at hand and refer to the list for possible relationships; (b) search for differences or collapse codes into one if too many memos on different codes seem the same;

(c) follow problematic digressions; (d) write conceptually, particularly about substantive codes, and do not talk about people; (e) in case of two ideas, write them down separately; (f) indicate saturation; and (g) be flexible.

I started memoing during the proposal writing and continued memoing during data collection and concurrent data analysis. I memoed in a variety of ways: Once an idea or insight occurred, I stopped and wrote it down; if writing was prohibited by circumstances, I created a voice memo on my phone. I wrote down the idea on a 3-by-5 inch index card or post-it note and stuck it to a board. I elevated the level of abstraction by writing down just one word, thus distilling the main meaning. If the idea was still percolating, I wrote down my question, vague feeling, and/or hunch. For ideas that were not incorporated, I created a binder called *loose ends* that I opened infrequently and reviewed. Memoing continued throughout the subsequent stages of sorting, writing, and conducting another literature search.

Sorting, writing, and the literature review. Sorting, writing, and the literature review are the final stages in the GT process. Sorting is an essential step in that “sorting puts fractured data back together” (Glaser, 1978). Sorting is the integration of theory, literally accomplished through sorting the memos. Sorting establishes connections between categories and properties. In short, sorting refers to conceptual sorting of memos into an outline of the emergent theory. Sorting leads to a theoretical outline and culminates in theoretical writing, which brings the research process to a close. Simmons (2010) explained that a write-up is transformed from a conceptual description to a theory (that explains something) by hypothetical probability statements that capture and explain variations of the core variable.

Once a theory is formulated, the researcher turns to the literature (both from within and outside the substantive discipline (referred to by Christiansen as contextual and

noncontextual literature). Extant literature at this point informs and refines coding, generates memos, and informs and refines the theory. Extant literature within the GT methodology becomes data. The literature review acknowledges what is known and thus leads to theoretical completeness. The literature review may add properties and categories (through the use of constant comparative analysis) to the discovered theory, and has the potential to modify the theory as indicated (modifiability is a characteristic of theory discovered through GT). Once the literature review is saturated, the appeal for future research is articulated.

The Research Sample, Sampling Methods, and Sample Size

The research sample. Given that the procedures resulting in CIP were common, ordinary, and frequent and that these procedures were performed in a broad spectrum of health care settings (including the home care setting), any registered nurse (regardless of whether the nurse had an ADN, BS, or MSN degree in nursing), who was willing to participate, was interviewed. The sample did not need to be subdivided, given that the existing knowledge about CIP did not justify the development of hypotheses or characterizations. For the study, both male and female nurses were considered potential participants if they were: over the age of 18, able to converse in English, and had worked or were currently working with an adult population in a broad variety of health care settings (hospitals, long-term and rehabilitation facilities, clinics, offices, home care settings, etc. I excluded nurses who had worked exclusively in pediatric and/or psychiatric settings. Instances related to children challenged one of the basic tenets of the phenomenon of interest: consent. Children cannot legally consent to procedures. Within psychiatric settings, the mandate for safety of self (patient) and others can create situations in which patients' choices are intentionally ignored or even suspended (e.g., so-called takedowns in which physical

restraints are being applied). Consideration was given to the exclusion of clinical situations, including a cognitively impaired adult (e.g., dementia) or any other adult patient who could not give consent, but given that the study was aimed at the experiences of nurses, this was deemed not necessary. Consideration was also given to clinical emergencies, given that emergencies frequently require immediate action and often do not leave time to obtain an informed consent. The initial thought was to exclude data related to these instances, but given the broad nature of the inquiry and the paucity of what is known about CIP, this appeared to be a premature exclusion that could not be defended. It was not known whether these scenarios created special (different) circumstances that affected how nurses viewed and acted in these situations. What was known is that nurses who were working on burn units had a very different perception of what constituted CIP as compared to oncology nurses (Madjar, 1998). This research was aimed at nurses performing everyday procedures.

Glaser (2001) cautioned that sampling, although readily identifiable at the onset, might evolve in unanticipated ways as a study progresses. This study commenced with sampling as described above. As a core variable and a theory emerged, I proceeded with theoretical sampling. Theoretical sampling aims to develop the emerging theory; it is a decision of what type of data to collect next and where to find the data. “The process . . . is *controlled* [italics by Glaser] by the emerging theory” (Glaser, 1978, p. 36). Theoretical sampling is different from purposive –sampling; theoretical sampling is needed for theoretical relevance.

Theoretical sampling could lead the researcher to unanticipated populations and settings (referred to by Glaser, 2001, as population spreading). Population characteristics typically are not known at the onset of a GT study; once a theory emerges, population

characteristics can become variables in the theory if noted to be significant. I avoided site spreading and remained with the original population (in order to comply and simplify human subjects' ethics disclosures and informed consent).

Demographic data are not routinely collected within GT methodology, unless data “earn” their way into the theory (i.e., they are found to be relevant to the emergent theory). Christiansen (2007) explained, “Because focus is on behavior patterns that transcend the limits of individual units, the data are collected by theoretical sampling and not by statistical or representative sampling” (p. 49). I collected the following demographic data: gender, age, ethnic background, marital status, highest degree in nursing, years since graduation, current employment status, and if indicated, primary position (staff nurse, charge nurse, manager, educator, other), and primary clinical employment (i.e., current field of specialty within nursing and full-time versus part-time or per-diem status). The collection of demographic data was required within the format of this dissertation. I was also curious to explore the observation that responses of nurses to pain (and pain infliction) appear to change over time. This observation could serve as a good example of how a preliminary literature review and/or personal experience can affect the researcher and research. It could be argued that this is an important insight that sensitized me to a particular facet, but it also could be argued that this amounted to preconception that could prohibit any other possible explanation. Collecting demographic data allowed me to describe the study participants and their experiences.

Sampling methods and sample size. I intended that the sample of participating nurses would be self-selecting (volunteer sample). I hoped to obtain a broad and diverse group of nurses representing various experiences. Patton (2002) cautioned that convenience sampling is fraught with low credibility and potentially yields information-poor cases. Morse

(1995) encouraged the selection of a cohesive sample but also recommended sampling all variations. I argued that a broad scope of nurses would provide greater diversity and could add to the richness of the collected data. This would likely support the assumed universality of the phenomenon. Therefore, I considered interviewing any registered nurse meeting the eligibility criteria.

Theoretical saturation can be viewed as a point of rapture, the point at which no new information is obtained. Morse (1995) described saturation as an edict of qualitative research, understood to mean data adequacy, and noted that no guidelines guide the process. Morse cautioned not to be swayed by frequency (i.e., the repetitiveness of “hearing things over and over”), noting, “It is often the infrequent gem that puts other data into perspective” (1995, p. 148). In other words, premature saturation may result in the loss of richness.

There is no criterion for the sample size within the GT methodology. Patton (2002) clearly stated that within qualitative research, purposeful strategies are used in place of methodological rules, and no rule could be found that determined the sample size. Patton placed the discussion about sample size within the context of breath versus depth and concluded, “No rule of thumb exists to tell a researcher precisely how to focus a study . . . These are not choices between good and bad but among alternatives” (2002, p. 228). Similar to Morse (2000), Patton noted that in-depth information from a small number of people can be very valuable (i.e., information rich cases). In addition, Patton noted, “The validity, meaningfulness, and insights generated [depend on the] observational/analytical capabilities of the researcher” (p. 245).

Thomson (2011) conducted an analysis of 100 grounded-theory studies in a variety of disciplines utilizing GT as defined by Glaser and/or Strauss and Corbin. Thomson restricted

the search to studies, which used interviews as the primary means of data collection.

Thomson noted that 12 of the studies conducted fewer than 10 interviews, 32 of the studies between 10 and 19 interviews, 33 studies between 20 and 30 interviews, 22 studies more than 31 interviews, and one study conducted more than 100 interviews. Smaller sample sizes appeared to correlate with the expertise of the researcher who interviewed the same participant multiple times. Thomson noted that saturation appeared to occur in between 10 and 30 interviews. Given Thomson's review, I planned to interview 10 to 20 participants.

Demographic data. Underlying the findings and conclusions of this study were one-to-one interviews. I contacted prospective participants and explained that this was an IRB reviewed and approved study. I explained the purpose of the study before meeting with participants for the formal interview. Verbal consent was typically readily granted; some nurses hesitated when encountering the written consent form, and one nurse withdrew her participation at that time.

A total of 14 interviews were completed, of which 13 were used for data analysis. The only interview omitted from this study was conducted on an impromptu basis, on the telephone, without being audio recorded (although notes were taken). Upon follow-up, the requested demographic information and consent form were not returned; thus the interview was not included.

With the exception of Kahuku Hospital and the Hawaii State Hospital, I was not able to gain access to any of the local hospitals on Oahu to distribute recruitment flyers. Kuakini Medical Center, Kaiser Permanente Moanalua Medical Center, and Castle Medical Center (CMC) denied access to their facilities soon after I made the initial contact; with the exception of CMC, no reason was given. I was able to obtain permission from Wahiawa

General Hospital but was not able to set up an appointment. Straub Clinic and Hospital required a physician sponsor. Queen's Medical Center required submission of a revised research protocol and requested modifications to the written proposal several months after submission of the paperwork. Tripler Army Medical Center granted preliminary approval, but the person in charge of follow-up stopped returning emails. Hawaii State Hospital (HSH), where I provide primary care to forensic psychiatric patients, granted permission to distribute recruitment flyers; I personally approached a number of nurses at HSH and recruited five participants. None of the five HSH study participants were under my chain of command.

With the exception of the excluded participant, all other study participants were known to me: two were close friends; three were known to me through social networks; one was a former student of mine; two were acquaintances; and five RNs were employed at the same hospital where I practice as an APRN/Rx. Four of the interviewees live in the continental United States. With the exception of the two close friends, no prior in-depth conversation had taken place with regard to the phenomenon of interest. I conducted the first interview on June 8, 2014, and the last on Nov. 15, 2014. Limited field notes were completed, primarily due to logistics dictated by my personal life or the circumstances of the interview (e.g., two interviews were conducted during my work day).

Interviews ranged from 15 minutes to 93 minutes. The median length was 40 minutes and the average length was 42 minutes. One person was interviewed twice. I was a novice researcher, and interviews, particularly at the beginning, frequently centered around, "What do you want to know." During the coding process, I realized how much I guided and limited the flow of the interviews by asking questions. Despite my lack of skill in interviewing, most study participants talked freely at some point during the interview and were eager to share

some of their experiences. I designed an initial questionnaire that I referred to in the first few interviews. I quickly redesigned the questionnaire after reviewing some of the transcripts. Transcribing, reviewing, and coding the interviews often showed me that I missed the essence of what was being shared in the moment, and I discovered the meaning later, particularly during the coding stages of this research.

Seven of the (13 utilized) interviews were conducted in public places (coffee shops, restaurants, etc.); one was conducted at a participant's home; two took place in a private conference room at work; and three were conducted over the telephone. All interviews were audio-recorded and transcribed by me. The motivation for participation was likely linked to knowing me and wanting "to help me out," as one study participant phrased it. Two interviews were conducted at Hawaii State Hospital with the knowledge and support of the participants' supervisors. Two participants were initially excluded given that the participants had worked only in psychiatric settings; but when I learned that both participants were recent graduates (less than one year), an exception was made, and the interview focused on their experiences in medical surgical settings. Several other RNs expressed interest but were excluded given that they had worked exclusively in psychiatric settings. Table 1 provides an overview of the interviews and Table 2 indicates my relationship to the study participants.

Table 1

Overview of Interviews

Total number of interviews completed	14
Number of interviews audio recorded and transcribed	13
Number of interviews utilized for data analysis	13

Number of participants interviewed more than once	One participant was interviewed twice
Length of interviews	Range of 15-93 minutes Median 40 minutes Average 42 minutes

Table 2

Overview of the Relationship of the Researcher to the Study Participants

Number of participants considered friends	5
Former student	1
Number of participants considered acquaintances	2
Number of participants recruited through current place of work	5

Participants' ages ranged from 31 to 65; the median age was 50 years old. The number of years since graduation ranged from six months to 43 years; the median was seven to eight years, and the average was 14.4 years. Ten nurses were female; three were male. Seven participants were Caucasian, one identified as African American, one as Filipino, one as Japanese, and three resembled the mixed ethnicity reflective of Hawaii. Seven were married, one was in a committed relationship, one separated, one divorced, and one participant was single. Ten study participants held at least a bachelor's degree in nursing, two had an ADN degree; one person did not have a degree in nursing because the participant was in an accelerated program that allowed her to sit for (and pass) the NCLEX examination. With the exception of two participants, all were employed full time (which may be a study limitation). Their primary position was (most) reflective of participants' current employment. Specialty setting was an ill-conceived category because most nurses had worked in a number

of different settings (see Table 3), and current position did not capture the breadth of experience participants had. One nurse who had worked primarily in pediatric settings was included, given that she also had worked with adults. I included two nurses who had only psychiatric experience as an RN; both were recent graduates, and the interviews focused on their medical surgical experience. I excluded a number of psychiatric nurses who expressed interest in participating.

Table 3

Demographic Data

Age	Range 31-65 Median 50-51	> 30: 2 > 40: 3 > 50: 6 > 60: 2
Gender	Female Male	10 3
Ethnicity	Caucasian African American Filipino Japanese Mixed: * Japanese, Caucasian * African American, Caucasian * Hawaiian, Chinese, Korean, Caucasian	7 1 1 1 3

Table 3 *Demographic Data* (continued)

Marital status	Married	7
	Committed relationship	1
	Separated	1
	Divorce	1
	Single	3
Highest degree in nursing	ADN	2
	BSN	7
	MSN	3
	No-degree but licensed; master's degree in a different field	1
Years since graduation	Range	0.5 – 43 years
	Average	14.4 years
	Median	7-8 years
Current employment status	Full time	11
	Contract work-per diem	1
	Not employed	1
Primary position	Staff nurse and contract	7
	Staff nurse-charge	1
	Management	2
	Management-education	1
	Education	2
Specialty, current clinical setting	<ul style="list-style-type: none"> • Hospice and palliative care • Emergency room • Gastroenterology outpatient clinic • Cardiology stress testing clinic and other procedures • Operating room • Psychiatric nursing • Home health • Combat medic in the army • Critical care - ICU • Medical surgical nursing • Geriatric • Administration - management • Staff development • Nursing education • Pediatrics 	

Entering the field. Glaser (1998) emphasized the importance of entering the field without knowing the problem, which requires suspending all prior knowledge (experience) and knowledge obtained from the literature. Glaser advised asking only three questions at the onset: What is this a study of? What category does this incident indicate? What property of what category does this incident indicate? Open-ended questions are a hallmark of GT methodology and likely will result in a greater quantity of potentially useable data. The study was designed as cross-sectional. I conducted unstructured interviews in settings that were comfortable and convenient for the study participant. I conducted and completed the interviews within one year of IRB approval.

Audio recording. Glaser (1998) pointed to the fact that audio recording only recently has become available to researchers through the use of recording devices. Glaser referred to audio recording as “one of the strongest evidentiary invasions into grounded theory” (1998, p. 107). He noted that the interviews traditionally are intended to provide evidence for substantiating or verifying a finding, thus setting the stage for descriptive capture (as opposed to theorizing). Glaser recognized that “recorded data is not ‘meaningless,’ [but] it is interchangeable” (2012, pp. 208-209). He argued that saturation of categories and their properties can be achieved without “plow[ing] through pages of irrelevant, transcribed data” (Glaser, 2012, p. 208) that unnecessarily adds work to the research process.

Patton (2002) explained, “Data interpretation and analysis involve making sense out of what people have said, looking for patterns, putting together what is said in one place with what is said in another place, and integrating what different people have said” (p. 380). Thus audio-recording is viewed as essential within qualitative research. I audio-recorded and transcribed the interviews and coded the transcription line by line. None of the participating

nurses objected to the use of a recording device. I generated field notes infrequently, primarily due to time constraints. I memoed as soon as possible after the completion of the interview.

Ethical Considerations

Various codes of ethics mandate the protection of study participants to ensure that the welfare of participants supersedes the so-called advancement of science (American Nurses' Association Ethical Guidelines in the Conduct, Dissemination, and Implementation of Nursing Research Protection, 1985; Belmont Report, National Commission for the Protection of Human Subject of Biomedical and Behavioral Research, 1979; Declaration of Helsinki, World Medical Association, 2008). The Belmont Report (1979) outlined three key principles: (1) respect for persons: participants ought to be treated as autonomous agents, which relates to issues regarding access to participants, informed consent, and confidentiality (Greaney et al., 2011); (2) beneficence (risk assessment); and (3) justice, which addresses the question of who is to benefit and who is to bear the burden of research.

The principle of beneficence requires that the researcher ensure the well being of the participants; therefore, I completed a risk-benefit analysis. Benefits for individual nurses may be derived from (a) being able to discuss a potentially troubling experience with the researcher, an uninvolved person; (b) gaining insight and/or knowledge about themselves, working conditions, etc.; (c) escaping from routine and excitement about study participation; and (d) satisfaction that the provided information could assist others (Polit & Beck, 2004). The question of potential benefits was best answered by returning to some of my own questions that I raised in order to resolve the personal dilemma that I was hurting people.

Who did I become as a result of this? Where did I draw the line? I postulated that CIP could be as relevant as PTSD and/or moral injury.

Jonathan Shay (1995) initiated a discussion about moral injury within a military context. Moral injury, as defined by Shay, is constituted by (a) betrayal of what is right, (b) ordered by someone with legitimate authority, and (c) occurs in a high-stake situation. Drescher et al. (2011), also within a military context, discussed moral injury in the context of inflicting trauma (perpetrating violence). This study could affect nursing practice, theory, and education—yet the anticipated effects were hypothetical at the time of writing Chapter 3. And lastly, although this research was not aimed at patients, it was my hope that patients would experience less pain.

I foresaw a number of potential risks. The probability and likelihood of harm or discomfort included but was not limited to:

- (a) loss of privacy and/or loss of confidentiality. Glaser (2001) noted that participants' revelation could not lead to betrayal of confidences, privacy, or identity, given that GT conceptualizes patterns that are abstract of time, place, and people. Glaser acknowledged potential emotional upset: "All research is subversive to some degree as it brings an awareness to participants that may effect some changes or upset them" (2001 p. 129);
- (b) potential emotional distress (disclosure of sensitive information during the interview that could raise uncomfortable feelings, such as embarrassment, shame, or guilt;

- (c) therapeutic misconception (a term used by Greaney et al., 2011). Refers to participants experiencing a false sense of hope in solving the various issues related to CIP; and
- (d) negative job consequences and possible stigmatization (nurses might become identified as “a problem”).

In case of extreme discomfort, a list of mental health professionals could be made available to the study participant. Overall, the magnitude of harm was considered minimal.

The principle of justice, and the question who receives the benefits and who bears the burden, address the issue of recruitment, particularly inclusion and exclusion criteria.

Inclusion and exclusion criteria were listed above.

Human Subjects

Fourteen registered nurse participants were recruited. I intended to advertise in local newsletters, hospitals and professional newsletters of nursing organizations (the Hawaii Nurses Association, the local chapter of the American Nursing Association, etc.), primarily in Hawaii with a preference for the island of Oahu. I prepared a recruitment flyer (see Appendix D) and a recruitment letter seeking permission to enter (see Appendix E). I was able to recruit participants via word of mouth. I included nurses from various geographic locations within the United States. A written consent was obtained prior to each interview with the exception of the first interview (see Appendix C for Informed Consent Form). Interviewing ceased when the participant indicated the need for ending the interview or saturation was reached. Study participants did not receive any payment or other tangible benefits; no costs were accrued for the participants. Participants appeared comfortable sharing their experiences and did not appear emotionally distressed. It is not uncommon in

qualitative research that the researcher may need to contact participants for further clarification; I interviewed one participant twice. I contacted study participants either by telephone, mail, or in person. The discovered GT will be made available to participants who desire to read the completed study upon the conclusion of dissertation defense.

Confidentiality of the interview data was maintained through a number of measures. Only I knew the names of the participants. Records and audio recordings were kept in a locked file cabinet in my home, and electronically stored information was stored on a computer with password protection and accessible only to me. At the completion of the study (or dissertation process), names and other means of identification will be removed and destroyed.

Evaluating Grounded Theory

Cohen and Crabtree (2008) made recommendations for evaluative criteria for qualitative research in health care. According to their criteria, I conducted ethical research: I explained the importance of the research; I provided a clear description of the research questions and background; I delineated the use of GT methods; and I presented my potential bias. Rigor (i.e., trustworthiness) was established by generating an audit trail (Rodgers & Cowles, 1993). The audit trail entailed contextual, methodological, analytic, and personal response documentation. In addition, I utilized negative cases (reports that CIP was not problematic), member checking, and peer review to avoid allegations of subjectivity and speculative analysis, thus providing more transparency. Cohen and Crabtree noted the absence of agreed-upon evaluative qualitative research criteria with regard to validity, verification, or reliability. Patton (2002) pointed out that different sets of criteria are used to

judge the quality and credibility of qualitative inquiry. These criteria are based on the inquiry purpose and the intersection with audiences.

GT is aimed at theory development. GT research does not test hypotheses and is not verificational. As such, GT must be evaluated in terms of its explanatory power. In 1967, Glaser and Strauss (1967/2009) proposed that grounded theory should (a) fit empirical data, (b) be understandable to sociologists and laypersons, and (c) work (i.e., provide relevant predictions, explanations, interpretations, and applications). Glaser and Strauss proposed that GT research have logical consistency, clarity, parsimony, density, scope, integration, and fit and the ability to work. They noted that the “adequacy of a theory ... cannot be divorced from the process by which it is generated” (Glaser & Strauss, 1967/2009, p. 5). In later publications, Glaser (1998) proposed a much-abbreviated list of evaluating criteria.

According to Glaser (1998), GT should: (a) fit: Does the concept represent the pattern of data it purports to denote?; (b) work: Does the core variable (i.e., theory) account for most of the variation of behavior in the substantive area?; (c) have relevance: Do the emergent concepts relate to the true issues of the participants; and (d) have modifiability: Does the theory have the ability to be modified through constant comparative analysis? Glaser (1998) found that “generation [of theory] is an ever modifying process and nothing is sacred if the analyst is dedicated to giving priority to the data” (p. 5). Glaserian GT is aimed at conceptual specification, not at conceptual definition (1978, p. 64).

Limitations

Being an RN myself posed the danger that I could be blind to certain aspects of a familiar situation or risk feeling companionship with nurses, thus preventing me from appraising a situation with a critical perspective. Distancing myself was an important task. I

was aware of my bias, and by generating an audit trail, including personal response documentation, I was able to approach the interviews and data analysis from a researchers' perspective.

I conducted this research to fulfill the requirements for a doctoral dissertation at the University of New Mexico. The discovered theory was linked to my ability to collect and analyze data (i.e., my theoretical sensitivity). I gained insight through peer reviewing and member checking.

This research was based on interviews with nurses who chose to participate and relied on what these nurses were willing to share. The perspective of "silent" nurses (those who did not participate) was unknown. I did not incorporate observation, and the congruence between what was reported and the actual behavior of participating nurses was uncertain. Another potential limitation was the small number of participants. It was not known with certainty how representative the sample of nurses was.

Although there was an interrelationship between nurses and patients, the patients' perspective was purposefully excluded. The discovered theory was induced and deduced from the data. While the initial research questions were purposefully kept broad, many of the participants' responses were shaped by the interaction between me (the researcher) and the study participants.

Given that resources such as time and money were limited, I made pragmatic decisions; particularly, I delimited the timeline and while I wanted to interview law enforcement officers and enlisted military personnel (because I hypothesized that nurses' experiences might not be unique), the discovered theory was limited to nurses.

Closing Remarks

There was no theoretical model that conceptualizes the experiences of nurses, who in the process of providing care also inflicted unintended pain. GT specifically aims to build a theoretical understanding of the phenomenon of interest and was therefore deemed a fitting methodology for this study. This study deviated from classic GT on a number of issues: literature review, audio recording, collection of demographic data and by adding a descriptive section. I did so in order to fulfill the requirements imposed by the University of New Mexico for a Ph.D. I did not deviate from the core of GT methods. In addition, I presented the ethical dimension of the study and provided a brief introduction of evaluation criteria for the study.

Chapter 4 Results

This chapter presents the findings obtained from 13 in-depth interviews. I identified the following key findings: nurses' experiences were unique and distinctly separate from the patients' experiences; nurses used, controlled, and constructed CIP; nurses utilized a number of processes to respond to CIP including asserting authority, taking charge, making CIP right by justifying and passing judgment, filling the gap, and transforming CIP by unmaking a patient's experience and remaking CIP; and, lastly, the significance of empathy and/or sympathy had for nurses. Empathy appeared to be both a problem and a solution in responding to CIP.

The findings of this study are structured as follows: findings with regard to CIP that appeared to be relevant to the experience of nurses; the emotional pain of patients; CIP as a social interaction; nurses and procedures; nurses and CIP: the effect of CIP on nurses and how they responded. This chapter closes with a summary of findings and conclusions.

Procedural Notes

Within the study's design, nurses who had worked exclusively with pediatric and/or psychiatric populations were excluded under the incorrect assumption that consent would be required and need to be obtained by nurses prior to carrying out procedures. Participating nurses had a contradictory relationship to consent: Nurses reported aborting procedures when patient consent was not granted but also proceeded despite a patient's expressed refusal or physical resistance. In responding to my questions, although unrelated to children, nurses frequently launched into stories related to children. Because incidents related to children could not be avoided and with the assumption that the sensory experience of pain is the same for children as for adults, incidents related to children were included. On occasion, nurses

also referred to instances of caring for psychiatric patients; these instances were included on a very limited basis. The reported incidents were either a nursing procedure (e.g., intramuscular injections of extended-release medications) or assistance in a medical procedure that resulted in CIP (e.g., electroconvulsive therapy). Nursing measures specific to psychiatric care that did not result in CIP were excluded.

The study was based solely on interviews, and I did not make any attempt to corroborate any of the shared incidents. It is possible that what nurses shared was “politically correct” and may or may not reflect what nurses actually did in practice. Given that I knew all of the participants, the participating nurses could have felt either more or less comfortable in sharing their views. Some could have shared their experiences relatively freely, while others could have become more guarded and protected themselves by not sharing certain incidents. I viewed what was shared as reflective of not only the perceptual experience of nurses but also of how nurses viewed and interpreted these experiences (i.e., the meaning nurses attached to their experiences). Body language was not closely tracked during the in-person interviews and was impossible to track during the telephone interviews. I paid close attention to rhythm, stress, and intonation of speech and inferred the emotional state of the speaker from that information.

On occasion, I encountered a language barrier, given that English is not my native tongue. At times, I struggled to find the right English word to capture the intended meaning. On the other hand, English being my second language has sensitized me to the meaning of words, and I habitually look for hidden meanings. Upon reading the interviews, I became acutely aware of how much I influenced the flow of the interviews by the type of questions and the timing of questions asked.

I viewed what was shared as a nursing discourse. During the interviews, I typically did not pursue what nursing meant to nurses, and I did not make any attempt to fit my findings into any given nursing theory. It was my hope that the study could spark future research and that the findings could be utilized in the advancement of nursing theory.

As expected with qualitative studies, I learned to ask questions of the data in order to gain understanding and to gauge the dimensions of the findings. I was the instrument. My inner work and reflections about the data generated a cognitive response, and it was the integration of my reflections and the words of the participants that comprised the full set of findings. The most difficult task was to break out of a mindset and view CIP as independent from patients and view the data solely from the experiences of nurses.

Findings with Regard to Clinically Inflicted Pain

Within a grounded theory framework, CIP was viewed as the broader context, or set of conditions, situations and/or problems to which RNs responded, and as such, many of the findings presented in this section were primarily contextual. Within the process of data analysis, it became clear that I could have pursued a number of different paths; I frequently had to make decisions of what was deemed important and how to proceed. This section is by no means intended to be comprehensive.

Who were the participants? At least one nurse and one patient were physically present when a nurse carried out a procedure. At times, several nurses were required (e.g., to turn, ambulate, restrain a patient, etc.). Although not typically physically present, there was an ordering provider who appeared to have some form of presence. On occasion, a family member was present, and the presence of a family member appeared to affect how nurses

viewed clinical situations. Therefore, providers and/or family members need to be considered as participants within the context of CIP.

The setting and relative secrecy of Clinically Inflicted Pain. Procedures typically were performed in an environment that permitted at least visual privacy. In some settings, there was no sound barrier: Pulled curtains and/or closed doors shielded the encounter from onlookers and thus created relative secrecy in which the interaction (CIP) took place.

Participant 13 described pulling curtains and interacting with a patient in a way that could be interpreted as a verbal assault. It appeared counterintuitive to define the situation as secretive because the patient was potentially always a witness. However, once the question of secrecy was raised, several other questions arose: Who tells the story of what happens behind closed doors? Is the patient permitted and/or capable of corroborating a story independent from the nurse? Who hears what story? Which story will be accepted as “true”? Given the potential for abuse, the relative secrecy in which procedures were carried out may be an issue with regard to safeguarding patients and/or nurses. The significance of this relative secrecy remained unknown.

Triggers and catalysts set procedures in motion. Procedures were initiated by a trigger (e.g., an order by a prescribing provider or adherence to an established standard of nursing care, such as turning a patient in bed every two hours, etc.). Procedures also were initiated by a catalyst, such as a provider, patient, or family member. I differentiated triggers and catalysts from motivation; I viewed motivation as a personal process of nurses, which I address in a subsequent section.

Procedures and painfulness of procedures. Nurses identified a multitude of nursing procedures associated with CIP. Participating nurses specifically mentioned mouth care,

perineal care after bowel movements, turning patients in bed, transfers and ambulation, rectal disimpaction, injections, starting and taking out an intravenous (IV) access, administering medications through IV lines, placement of various tubes (specifically mentioned were indwelling Foley catheters and nasogastric tubes), nasopharyngeal and endotracheal suctioning, wound care, and dressing changes. Conflicting accounts of the painfulness of a procedure were noted. A nursing procedure in and by itself appeared not to be a reliable predictor of associated pain. Although an obvious fact, one of the most important findings for me was the realization that nurses could not share the sensory experience of pain. Participant 13 said, “When you’re taking blood or giving a shot to a patient, of course you’re not feeling it. You see the patient’s reaction; I mean you don’t feel the pain.”

Unintended pain. In the earlier stages of this dissertation, I used the term unintended pain to indicate that the infliction of pain was not intended. Nurses were aware of the possibility of CIP associated with a number of nursing procedures. Participants 8 and 9 argued that there was “no intention of harm.” The participants made a valid point, and thus I dropped the verbiage “unintended.” Nurses appeared to acquiesce to the effects of CIP.

You know, it’s mean. Yeah, I think you have to be in a way a little hard-hearted to be a pediatric nurse because you are doing things that are mean and that they can’t understand why sometimes. I mean, it’s not that I’m doing it intentionally like, ‘Mah-ha, I’m going to go hurt this child.’ But, you can’t say, ‘Oh, I can’t do that. I can’t hurt that child.’ You have to. Sometimes you do things that are gonna hurt, and you have to do them, and you know you just have to kind of suck it up and be the mean one for a little bit. —Participant 9

And: Unintended pain. The, um, see if I can get in the flow here. The, um, part, the, I mean, part of it is I’m actually having an interesting, a little bit of a reaction, not reaction, but I got a little blip on the use of “unintended pain.” Because it’s not exactly unintended, it’s, or it’s like, um, what’s the sense of it? It’s like, um, uh, it’s gonna take me awhile to get going here. The, um, it’s like the, the needed pain to get to a goal, as it were. So, there’s no intention of harm, you know, so it’s not pain that has

been intended to harm, it's pain that's like a necessary part of getting to the goal of healing. —Participant 8

And: Oh, I was just going to say, because saying, 'unintended pain' sounds a little bit more like, it, it depends, but it sounds a little bit more like you're saying, 'Oh, I didn't know that would hurt.' Like, 'I didn't plan this IV would hurt.' You know, it has a little bit of a nuance in some ways, of like, I didn't see that coming. But I think what you're talking about is, knowing this is going to hurt somebody, how do you handle knowing that what you do is gonna cause, like, immediate or short-term pain in some regard, to the patients. —Participant 8

Clinically Inflicted Pain was unavoidable. CIP was a likely and anticipated occurrence associated with common nursing procedures carried out on a daily basis. As such CIP was unavoidable.

We do those things every day, every day. Whether it's starting an IV, putting in a Foley, NG tube, wound dressing changes, a lot of patients in the IC, just turning them is painful. We get a lot of back surgery patients, too. So, for those ones, it's trying to get them out of bed and move them around the way they're supposed to, so they don't get pneumonia. We do painful things to patients every day. —Participant 5

Not carrying out a procedure could have had equally bad or even worse outcomes, and nurses verbalized anticipating guilt as the result of not carrying out a procedure. This added another dimension to the unavoidability of clinically inflicted pain.

Clinically Inflicted Pain was treatable. Participants 4 and 12 spoke about mentally preparing the patient.

So, you can imagine that that was painful. And what we had done, is we had worked with her to give her pain medication beforehand. And, um, get her set and get her mentally set to do the dressings. Then two of us would go in there, and we'd lay everything out, and we would explain, always, before we did it, what we were gonna do, and what the reason was. Because we explained to her, and she's had it, heard this more than once, the wound has to heal from the inside, out. So, when we were doing it, we would try to make her comfortable, as much as we could, with the pain meds. —Participant 4

And: As a manager and in leadership in an acute care setting, I preach the same thing to my staff, and I tell them that our goal is to make sure the patient understands what's happening, and we give them as much information as we can about what we're going

to do, and what might happen. And we also try to prepare them physically or mentally in the best-case scenario, and if they ask for medication, or they request this or that, then we try to accommodate them. —Participant 12

Several nurses utilized pharmacologic measures. Nurses specifically reported using topical anesthetics as well as pre-medicating a patient with an analgesic medication prior to a painful nursing procedure. Nurses, however, also described the limitations of premedication and called the efficacy of premedication into question, which created a dilemma for nurses that left them without effective pain relieving measures. Nurses appeared to feel powerless under these circumstances.

So, all of the pain meds, you know, you couldn't give them enough pain medication, which was horrifying. —Participant 10

And: I remember when I had a chance to work on the burn unit. I kind of just refused, because I kept thinking, 'Well, I know these guys do feel pain,' and when you have to clean, you're scrubbing. And, you give them pain meds before, but, it still didn't make me any more comfortable with it. I mean, I just wanted to cry. I was, I remember listening to another student talk about it, and she was so excited, and I just thought, 'I just want to cry. That's someone's body. You're scrubbing away a layer of skin,' and it's just, yeah. Pain meds or not, you cannot take away all that pain. — Participant 11

And: So somebody comes in, and we're intubating them, and they're fighting and struggling, and we're tying them down, and we're giving them drugs, and they're scared, and they're fighting, and things hurt. You know, we're putting lines in, and we're, you know, he's tied to the bed on a ventilator, which I think is a horrible experience, you know. The, um, if they, there's every reason to think that they're going to have a good outcome, it's like, I feel good about doing that. As long as I do it in the kindest, most merciful way possible. Which is to give them plenty of drugs, and, and to be as kind as I can in doing it. —Participant 8

Participant 13 challenged the patient's request for a topical anesthetic in order to reduce CIP and offered "distracting" the patient as a valid alternative to ease CIP:

Exactly, so that's where a lot of distracting techniques come in or distracting the patient, talking to the patient, um, you know, what's worked in the past, basically. Some patients work by getting the lidocaine injection before they get an IV placed. I'm like, 'That's two shots, right? Why would you want that?' You know, they've

done it in the past and like it. Oh, OK, whatever. Whatever works for you. So, if you want that, that's what I'll do. I find distracting and talking to the patient and being confident in what you're doing. —Participant 13

Participants 8 and 10 noted that the attitude that a nurse brought to a procedure and/or the patient was at least as important as utilizing pharmacologic measures.

And so that was a total like my whole goal that night was to be as gentle and as kind and as, you know, not harassed and not short-tempered and not, you know, exasperated and kind of huffing and puffing every time I went in her room, but to just basically go in and just very gently move her. Anyway, it—I felt, um, so [whisper][inaudible], and I'm just thinking about that, and in that sense I don't think, I don't think I was thinking about invading her body space. I think I was thinking more about her emotional state and that you can, again, you can damage that by your attitude and your handling of what's going on with the person's body. —Participant 10

And: I do whatever it is in the kindest way possible, with the greatest compassion, and the truest intent, and it actually, you know, kind of my best belief or understanding is that this will benefit this person. I'm willing to go through the situation of that person screaming at me, or, or whatever else it is. You know, although I don't like it at all. —Participant 8

Participant 13 not only indicated that nurses had control over CIP but also directly tied CIP to the skill level of the nurse: “The most painful procedure will likely be an IV if you don't know what you're doing.” From these quotations, it was obvious that nurses utilized a variety of measures to at least alleviate CIP, which led me to conclude that CIP was treatable.

Clinically Inflicted Pain was different from other pain by its injurious nature.

Madjar (1998) reported that patients differentiated CIP from other pain by its injurious nature. The potentially injurious nature of CIP was not lost on nurses.

I mean, I would never inflict pain unless it was necessary. I would not go around like mugging someone, or shooting, or hitting someone unless there was a good reason for it, and I think as a nurse, that's why we're doing this. We're doing this to help this patient. —Participant 13

And: It's like it's not, um, it's almost like doing that which is hurtful, when there's no hope of good outcome for the patient, is more what's at issue. You know, in terms of feeling bad about it myself. When I feel bad about causing harm, it's like, say, we have an 88-year-old grandma on the ventilator with end-stage lung disease, or she has a big stroke, and this family can't let go. —Participant 8

Emotional Pain of Patients

I included this section to remedy a blind spot within my own perception as well as to acknowledge the importance that some nurses placed on the emotional effects of CIP on patients. I also wanted to emphasize the discovered impact and significance of empathy. At least six of the participating nurses talked about emotional pain of patients in conjunction with procedures. For these nurses, the emotional pain and fear were at least as important if not more important than the physical pain associated with procedures.

The conflict is that I'm causing them that level of, of emotional fear and pain as well as the physical pain. And that that is in and of itself, you know, damaging to the person. Um, but that's a conflict that I am doing harm, is the conflict... I think I was thinking more about her emotional state and that you can, again, you can damage that by your attitude and your handling of what's going on with the person's body. —Participant 10

It was interesting to note that Participant 10 pointed to a nursing discourse that discouraged an emotional connection with patients by calling it a “professional relationship”:

Well, you were either going to create a personal relationship with that patient and with that family, in which you cared about what happened and therefore the pain that they were going through, you felt with them . . . Or, or you could have a professional relationship with them which did not involve your emotional investment or your experience of their pain [crosstalk] on a personal level. —Participant 10

Clinically Inflicted Pain as a Social Interaction

Although important, the nurse-patient interaction was not the focus of this study, and this section, similar to the preceding sections, was primarily intended to be contextual. By social interaction, I refer to an encounter between a nurse and a patient, which might be

verbal, visual, or tactile (e.g., picking up a child or physically restraining a patient). The nurse and the patient appeared to affect one another, described by Nagy (1999) as interrelationship. This section shows the various ways in which nurses related to patients and uncloaked some of the complexities associated with CIP. I chose quotations that I perceived as representative of most of the participating nurses and quotations that captured a particular facet that appeared to be important. This section is not intended to be comprehensive.

Relating to patients. Participant 5 and most participating nurses reported that they explained procedures to patients and sought what could be construed to mean consent.

I explain that to them, and they understand that. Of course, it's not fun to be in pain, either. With all of the procedures, everything, I always explain to them, 'This is going to be painful,' or 'This is going to be uncomfortable, but this is the reason why we need to do that.' Usually they say, 'OK,' and they understand that it really is in their best interest. —Participant 5

Participant 13 gave a patient a choice before proceeding to carry out a procedure.

So I talk to them, you know. 'I'm going to stick you one time. If there's an issue, I'm going to get someone else.' And they was like, 'No, no,' they, and most patients will say, 'Oh, no, no, please try again,' or something like that. They don't want me to get anyone else, but they know I know what I'm doing. It's just, and the patient will tell you all the time, 'Oh, don't worry. I have hard veins. I'm a hard stick. They stick me five and six times.' I was like, 'We're not going to stick you five and six times. I'm going to stick you twice. If I don't get it, we're going to get someone else because there's always someone else,' you know? So, yeah, so I think by talking to the patient, reassuring them, making them feel comfortable, and that confidence is very important. —Participant 13

Participant 12 listed the steps she took in preparing patients, and in an effort to alleviate CIP she voiced a commitment to treat CIP and pointed out to patients that she could ease CIP only if the patient communicated discomfort to her.

So from my perspective as a nurse, I will tell you is that I am always concerned mainly about explaining to the patient what's going on, what we're going to do, it might hurt, it might not hurt. If it does, if there is a possibility, I like to plan by trying to prepare them on pain meds. That's what I've learned as a nurse. If I can, I try to

prepare them as with a wound dressing. We try to do, um, preparation, pain medication half an hour before to make sure that they're comfortable. Um, in my experience if I am doing something and it does cause a pain and they let me know, then I will stop, reassess the situation and then see if we can maybe do this in a less painful way or we can try getting them medication or something to calm them down or have them with less pain. —Participant 12

Nurses rarely spoke about the actual interactions with patients while carrying out procedures. Participant 9 described apologizing.

And you apologize profusely, and you do it anyways. You explain as much as you can. I do. Um, I answer them honestly if they say, 'Is this gonna hurt?' Um, and I just keep apologizing. [Laughs]. 'Cuz I feel terrible, I feel terrible [emphasis]. But I do it anyways because I know I have to do it. —Participant 9

However, her apologies were not unconditional:

I mean it's hard to be compassionate to someone who is rude to you over and over again. So, you might become less nurturing. You know, I don't know that I would be more willing to inflict pain, but and this is like, you know, an 18-year-old, so I might be less apologetic afterwards. —Participant 9

Opinions about patients revealed that nurses constructed their estimation of the painfulness of Clinically Inflicted Pain. This section sheds light on the fact that nurses had preconceived opinions about patients, which affected how nurses viewed inflicting pain. Participant 11 described a response by a patient who was “fighting,” which she interpreted as a response to pain. The patient’s response elevated this patient, who she thought of as a “vegetable,” to the status of a person. Participant 11 then labeled her actions as cruel. This observation raised the question of whether CIP could be an important feedback mechanism for nurses.

And it made me think about my own kids, and it was just, it was really hard. I remember the first patient I took care of. She was practically a vegetable. She was 7. She smiled, but I never knew if it was just instinctively, or, you know. I remember brushing her teeth, and that's when I learned that, I forget what it was called. I think it was Chlorhexidine. I don't know what, but whatever it was that I used, it burned her mouth when I used it. I remember having to suction, and I felt so bad, because I knew

that if I didn't clean her mouth good, that bacteria, and she could get cavities, and just all these different things could happen, if I didn't do my care, as a nurse, well. But, at the same time, I just remember looking at her, and she kept fighting, and I thought, 'Well, this person who I had thought was a vegetable was not that much of a vegetable, because she could feel pain.' I remember, I just, I cried, because it was so, for me, it was disheartening. I kind of felt like I was being cruel, and I remember my instructor came in, and she's like, 'You need to toughen up.' —Participant 11

Participant 6 described the painfulness of spinal anesthesia in a general context. In the next quotation, Participant 6 presumed that the patient was a gang member. His verbiage to describe CIP changed: "a lot of pain . . . they'd scream out" became "the least little pinch." Same procedure, different patient, and the descriptors used for CIP changed drastically. This revealed that nurses used their perception of patients to construct the painfulness of CIP.

Other types of pain were when the patient is placed on their side and told to curl up in a ball, and they're given a spinal anesthesia. So a lot of times, my job would be to hold the head and the legs to make sure they're held in that position and that they're not moving, and then the anesthesiologist preps the area and inserts the needle. Lot of people had a lot of pain with that. They'd scream out, say 'Ow,' you know, and yell, 'That really hurts,' and they'd say, 'Sorry, sorry,' and they'd poke around, the anesthesiologist, to find the right spot, cut the area and insert the needle. —Participant 6

And: I think [I am] more compassionate towards the elderly people. Why? I think – well, some of the young people were like – OK, I'll give an example: One that was getting a spinal anesthesia was a gang member, and he was supposed to be a tough guy, right? And so he was Hispanic and he had these tattoos all over, but when they were trying to do the spinal, he'd cry out, say, 'Hey, man, you're hurting me, you're hurting me, man, you're hurting me,' and he'd get all angry. So because he's angry, and I'm thinking this guy is supposed to be a tough guy. He's a gang member. How come he's screaming out over the least little pinch in his lower spine for the spinal? So to be honest, I didn't have a lot of sympathy for him versus an elderly woman who is frail and fractured her hip. —Participant 6

Accountable to whom: Example of a “successful” procedure. Nurses were accountable to a number of different constituents: providers, nurse managers, peers, patients, family members, friends, nursing standards and ethics as well as their own conscience. Nurses, at times, encountered competing and conflicting demands and had to make choices.

These choices were influenced by who (or what) nurses chose to affiliate with. I postulated that affiliation was linked to accountability. Participant 10 affiliated foremost with patients: “I guess the ultimate authority is the patient.” Participant 7 needed to establish a relationship before the patient could become one of the “most important people:”

And it’s funny because the old saying is true that you don’t know him; he doesn’t mean anything to you, but when they call your name, and they call medic, then next to my parents, they’re the most important people in my life. You’d do everything you could to, you know, save him, and I could still hear their cry. I could, you know, see their faces. —Participant 7

The following quotation highlighted the fact that nurses had choices about where to focus their attention.

I kept running through all the steps that you take when you do a suction. And I focused on that, because I could see my patient starting to tear up. And it was just, when the whole thing was done, I, I just kept thinking, ‘Oh my god. I’m such a monster.’ And I felt so bad. Because it was like . . . Meanwhile, everybody else was like, ‘Oh, good job, good job.’ And I was like, ‘Good job? Look at my patient. He’s now afraid of me.’ . . . And I kept thinking, I looked at my instructor, and I looked at the nurse, and I kept thinking, ‘Neither of them seem to care that the patient was there, crying,’ and I just thought, ‘Wow. That’s so mean.’ —Participant 11

In this quotation, two distinctly different definitions of an outcome (i.e., success of a procedure) were contrasted. In procedural terms, the then-nursing student succeeded in suctioning the secretions of a patient. Yet Participant 11 said she “Felt so bad.” Her focus was on the patient who was crying after the procedure was completed; she expressed concern that carrying out the procedure had seriously damaged the relationship the patient had with her, the nurse. The nursing instructor and the attending nurse applauded the student for accomplishing the task of suctioning. According to the then-student nurse, the nursing instructor and attending nurse did not “seem to care” (neither the nursing instructor nor the attending nurse were noted to comment on the patient’s response). For Participant 11, the

relationship her patient had with her was sufficiently important to not only be noted, but to have the highest priority, and successfully completing the procedure was second priority.

Participant 10 differentiated between a task-oriented versus people/process-oriented approach to nursing and this model could explain this clinical situation. Although these two orientations are not mutually exclusive, they typically result in different priorities or different endpoints and impact how the success of a procedure could be defined. I did not know whether the distinction between task-oriented versus people/process-oriented approaches sufficiently explained the reactions of nurses involved in this clinical situation.

Torturing patients revealed the constructed nature of Clinically Inflicted Pain.

Nurses utilized the verbiage of torture within the context of CIP. Participants 8 and 10 made references to torture in conjunction with caring for patients who died after a prolonged critical care stay and when nurses projected medical futility for patients' under their care. Participant 5 used the word 'torture' in conjunction with children because a young child lacked the intellectual capacity to understand what was being done.

And, then, we're torturing that woman because everything we do has no hope of good outcome for her. That makes, that just upsets me. —Participant 8

And: Then, I was extremely angry because he had a very hard time managing his secretions, and I got in a big fight with the head of the intensive care about when he transferred to the floor because I didn't feel that it would be safe for him to be on the floor, um, because his secretions were so thick and he did die on the floor of basically a, uh, basically a mucous plug. And I felt like we had possibly tortured this man for like two months against his will going with what his grand-nephew said, not taking the time to figure out what he wanted, and then after they were kind of done, they transferred him to the floor knowing that it was possible that at the floor he would die, and he did. —Participant 10

And: Then, just the whole, normally adults will sit there and cooperate with you, whereas kids typically don't. Then you feel bad, because they don't understand. When I explain to an adult, 'This is what I have to do to you, and yes, it's going to hurt, but this is why,' they understand. They have that cognitive understanding. Whereas kids,

you're just this little monster coming to torture them. They have no understanding of why you have to do what you have to do. —Participant 5

I discussed my perception of the publications by Hinsch (1982) and Sandroff (1983) with Participant 8. I described that the nurses appeared haunted by CIP. Participant 8 had an interesting response and referred to the nurses themselves as being tortured, implying that inflicting pain could have a negative impact on nurses. Within this study, several participants reported remembering faces or memories that lingered; some participants were still noticeably distressed when recalling instances related to CIP.

And in burn units, you do probably the worst ever pain that you can imagine, and you do that every day, for weeks. So, it, it, when I, kind of, I'm actually very much like you. I let things kind of percolate and see how it connects and what words connect with it. And I thought, she's going through hell, she's in hell doing this. She's so, so haunted, tortured, um, uneasy, it's so difficult for her. Um, this is, kind of, and it doesn't get spoken much about, so it's the unspoken, or the, the dark, or the underworld, we're going into places people normally don't go to. —Participant 8

Nurses appeared to enter a bargain when agreeing to carry out painful procedures. Nurses were willing to carry out procedures if there was a perceived benefit (e.g., positive outcome); however, if there was not a projected good outcome (i.e., projected medical futility), nurses struggled, questioned the necessity of procedures, and found ways to avoid carrying out these procedures (e.g., attempting to carry out a procedure only once or explaining to patients or their families that they had the right to refuse). Framing CIP within the context of torture appeared to be an indicator of the depth of the conflict nurses faced. Some of these experiences appeared to haunt nurses; the significance of these haunting memories remained unknown. For this study, the context of torture was significant in terms of attributing meaning: Same procedure—different circumstances, different meaning. I

concluded that nurses not only constructed their estimation of the painfulness of CIP but also constructed CIP itself.

Taking charge: Having and exercising power over patients. Proceeding without consent was a common occurrence with regard to demented or deemed incapacitated adults and young children.

You're doing something to somebody who's screaming and crying, and raging at you, and thinking you're horrible, and you're hurting them, which can be a child, a demented person, or a normal-state-of-consciousness person, who is temporarily out of their mind. —Participant 8

And: So, for me that wasn't that frequently, and most of the time the person wasn't conscious, or the person, I would take the time to explain what I was doing. Um, I am trying to think of what—so, even the guy who we did, he didn't say no. The only person that said no would have been that little child and then maybe one or two dementia patients. —Participant 10

And: Well, I think as far as fighting, that's little kids and our demented elderly patients, and most of the time we're doing it because they need medication. They need fluids. So you're going to get some assistance. That could be two female nurses, a strong guy, someone to hold them so you can get that IV in place, and then once it's in place, of course we have to watch they don't pull it out, so are you going to, um, what is it called? Uh, what do you call it when you tie someone down? —Participant 13
Interviewer: Oh, restraints.

And: It is hard with little ones, like under 4, I'd say, I mean maybe under 3 that definitely have someone there. A lot of times explaining doesn't help at all. They're just so scared when you're gonna do something. Um, you can try and explain, and they're just like beyond, they're just scared. You know, and they can't concentrate on directions. And sometimes, then you just do it. You know, I hate it. You know, putting in an IV, you just have to hold the kid down and do it, um, and get it done with. Um, it's often the biggest thing, get it done with. —Participant 9

Although nurses reported obtaining consent, several of the nurses reported instances in which they proceeded against patients' explicit refusal or resistance. I listed only one quotation here as I have listed other quotations pertinent to this observation in other sections.

So not only was the patient, the soldiers, and the local nationals was in pain already, cuz for whatever traumas they had, like gunshot wounds or amputations, and on top

of that, you still have to quote, unquote, inflict pain when you couldn't find the vein for an IV, so you've got to do a FAST-1 on the sternum, or somebody got shot and you know they're having a hemopneumo on the right side, then you know you got to decompress that, that chest, so . . . I'm gonna kind of block that, even though you're yelling and screaming and swearing at me, I'm going to block that 'cuz I know what I'm going to do to you, it might just save you. —Participant 7

Participant 12, who had worked as a nurse manager in a long-term care facility, placed and discussed CIP primarily within the context of pain management; she described the lack of adequate pain management in the context of “borderline abuse.”

Interviewer: In long-term care . . . Um, and one of the things that you do a lot in long-term care is turning people, changing briefs, diapers. One of the most painful experiences for a lot of the residents. And when I present my research, the nurses always say, ‘Yeah, what you gonna do about it? I mean, do you want to give pain medication when you change a diaper?’

Interviewee: No, I, what I had to do when I found that a lot, because I thought it was borderline abuse when I got there. I would, um, talk to those staff, one by one, and tell them that's not acceptable, and then educate them. And this is my, this is what I expect of you, to treat every person with dignity and respect, and also understand that although they can't talk to you, or can't make contact, verbal communication with you, you have to respect that they may have needs that they can't communicate. So you need to be aware of that. —Participant 12

I conclude this section with a quotation in which a nursing instructor encouraged a then-nursing student to proceed against the resistance of a patient.

I recall, I recall, um, putting in a urinary catheter, and I, that, I did not feel good about that. So, it was an elderly Japanese woman, and, and my nursing instructor and some other students were there. And it was determined, OK it was my turn to learn how to do this, and I would do it. Which, I was fine with that. It's a good opportunity, actually. But the woman who only spoke Japanese, and I didn't know but a few words of Japanese, clearly, uh, was objecting to the whole idea. You know, I didn't speak Japanese so I don't know in what way she was objecting or what her mental capacity was or anything else. But it had been determined that she should have one of these, and I should be putting it in. And she clearly was against it or not adequately informed or whatever. And, um, yeah. So, I don't remember all the details, but I remember somehow in the process I got like, I got like physical, a small physical injury. Like she, you know, dug her nails into me or I don't know exactly how she contorted to injure me slightly, but I remember the nursing instructor apologizing to me for, you know, allowing the situation to be such that I got my little, you know,

injury. And I was like, ‘This seems all wrong to me. You should not be apologizing to me.’ I’m, you know, like, yes, I’ve got a little cut or something, but I’m not really hurting. She, on the other hand, patient here, she’s hurting. I felt like we were wrong. I mean, maybe she really needed the catheter, but boy, I didn’t think we should have done it then. I thought somebody should’ve . . . We should’ve gotten a translator, and somebody should’ve gotten her to understand or she, or she should’ve had the right to refuse. —Participant 14

It was difficult not to be swayed by a reaction in defense of the patient and the patient’s rights. I was concerned that in condemning this kind of conduct, its meaning, and the function it has for nurses could get lost and, in addition, that this type of conduct could continue where it would be less visible and thus unchecked. Several things appeared to be important with regard to Participant 14’s comments. Before proceeding, I wanted to make clear that I did not know the reasoning behind the nursing instructor’s encouragement; my questions and conclusions were based solely on possible explanations. I was making the assumption that there was nothing unusual about this clinical situation, and it appeared likely that the nursing instructor encouraged the then-student nurse to proceed in good faith. Equally likely was that there was nothing unusual about encountering resistance and proceeding to carry out a procedure against resistance. This instance possibly revealed how common these clinical situations were and that proceeding against resistance was “normal.” It was likely that the nursing instructor viewed this clinical situation as a teaching opportunity. This nursing student was taught to respond to patients by overcoming resistance and that the completion of the procedure mattered most.

Transgressing into personal space. Participant 8 framed having and exercising power over patients within the context of transgression into personal space. It struck me as a poignant capture of what nurses did within the context of CIP.

Certainly, there's a huge, um, invading of personal space that, um, it, it's like we, it's like we relatively are going on, um, all right. I'm gonna say it in bad English, and then we'll see if it comes out. It's like, invading people's personal will or transgressing their personal will and their personal space, as more of a prohibition. It's like, at what point do we have the right to, um, have somebody saying, 'No,' and we're gonna say, 'Yes, I'm gonna do this for you. I'm gonna do this to you,' regardless if you're screaming and saying, 'No.' —Participant 8

And: I keep thinking of it, kind of, you know, more like, like, kinda like the end justifies the means, to a certain extent, not absolutely, but relatively. It's like, if, if the goodness of the outcome outweighs the discomfort and, you know, transgressing of personal space, you know. It's like, if I know that tying this person down and shoving a tube down their throat is gonna save their life, even though they're screaming, 'No,' that I know that this person has something that is, um, reversible, and they're gonna be OK, and they're gonna live, you know, have a chance at living the rest of their lives in a good way. It's like, I feel fine doing that. —Participant 8

In subsequent interviews, I explored the idea of transgression into personal space. Participant 9 described this phenomenon in terms of boundary violations and loss of autonomy.

Although it appeared as though Participant 9 addressed the same issues as Participant 8, the verbiage reflected the experience of patients as opposed to what nurses did and how nurses framed their experience. Transgression into personal space appeared to be a common occurrence.

You are not respecting their boundaries. Yeah, all the time, and that's part of the whole thing for me. The same thing as inflicting pain is they don't get to say 'No' when they want to say 'No.' Or they're not—they're not always allowed to say 'No.' I mean sometimes, you know, I say, 'Do you want to do it now or do you want to do it in 10 minutes?' You know that way, they can say 'No' a little bit, but, yeah, um, we have to do things. You know, you don't have a choice sometimes. And you know, like I say, you let them get away with what you can, but yeah, you transgress on personal boundaries all the time. They're—unfortunately, you lose so much autonomy in the hospital whether you're a kid or an adult. —Participant 9

Transgression of personal space did not resonate with Participant 10. Transgressing into personal space added another facet to CIP; it captured and described nurses' conduct.

Closing remarks. In this section, I summarized nurses' reported conduct. In doing so, I assumed that individual nurses were representative of other nurses: Nurses informed patients about procedures, acknowledged the potential for pain, and encouraged patients to communicate discomfort. Nurses consistently reported explaining procedures, or providing a rationale why a procedure was indicated, and obtaining consent. Nurses worked with patients by giving patients choices or asking for their assistance in carrying out procedures. Nurses promised to institute pain-relieving measures if patients communicated discomfort. Nurses were willing to abort a procedure and explore alternatives if nurses concluded this was indicated. But nurses also exercised power and in some instances proceeded against patients' wishes and/or expressed refusals, described by one participant as transgressing into personal space. Exercising power appeared to be a common occurrence. It appeared that nurses did not view exercising power as problematic per se. At the onset of the data analysis, I had viewed exercising power as problematic, within my understanding of the role of nurses, and contradictory to caring. After completing the data analysis, I drew a different conclusion: Exercising power only revealed the full scale of nurses' reported conduct; exercising power was only a possible endpoint on a continuum of nurses' conduct.

Nurses were accountable to a number of constituents. Nurses chose their affiliation, which affected their reported conduct and how nurses defined the successful completion of a procedure. The most important findings from this section were the discovery of the constructed nature of the nurses' estimation of the painfulness of CIP and the constructed nature of CIP itself.

Nurses and Procedures

This section, similar to the preceding sections, provided context.

Motivation: Obedience and service. I differentiated between motivation, defined as a force or an influence for acting a certain way (based on Merriam Webster, 2015) and justification, defined as the action of showing something to be right and/or reasonable (based on Merriam Webster, 2015). Motivation answered the question of what propelled nurses to carry out procedures; justification answered the question of what made it right. An order or accepted standards of care legitimized carrying out a procedure. Nurses' conduct could be viewed within the context of obedience:

- And since I was a night shift nurse, I had to do all the labs in the morning. So, I would read the doctor's orders and see what lab work was, was ordered for that particular patient, get the correct tubes and everything. And then I would go in ahead of time, without any of my equipment, and explain to the patient. —Participant 4
- And: It's all done under the doctor's orders, you know, so uh yeah. —Participant 6
- And: And I just go in there as a professional nurse, OK, this is doctor's orders. This is what we're doing, and this is the amount of care that we're going to be doing based on the needs of your child. —Participant 7
- And: It depends, like I said, for a baby who is dehydrated that needs fluids, yeah, it hurts me to have to put a hole in their arm, but that's life saving to them because we know when a baby dehydrates, they can go downhill really fast, or even a demented elderly patient or anyone who is confused and fighting you, doesn't want the NG tube in, doesn't want the IV . . . You're not doing that to be doing it. You're doing to because you have a reason. You have an order . . . —Participant 13

Nurses also were motivated by wanting to help patients; nurses were compelled by a strong sense of service and even duty.

I don't like inflicting pain on my patients, but I understand that by doing the procedure, they're better off. Especially with the surgical patients. They need to get up, and they need to move; otherwise, they develop more complications. The healing process is just faster when they get out of bed and move. Even though they may hate me for making them do it, eventually the outcome is better. I explain that to them, and they understand that. Of course, it's not fun to be in pain, either. With all of the procedures, everything, I always explain to them, 'This is going to be painful' or 'This is going to be uncomfortable, but this is the reason why we need to do that.'

Usually they say, ‘OK,’ and they understand that it really is in their best interest. — Participant 5

And: But it’s not my decision. It is my duty, a military value. It is my duty to take care of that person. And I’m gonna do it. —Participant 4

Not carrying out a procedure had consequences that were potentially damaging for patients. Not carrying out a procedure and patients suffering adverse outcomes were interpreted by nurses as neglect, and nurses anticipated feelings of guilt.

Well, I just, I think I just learned to accept it. Because, like you said, it was something that needed to be done. With the burn patients, they’re in terrible pain, and it’s awful. It’s awful to have to change their dressings, and you feel terrible, but you know if you don’t, it gets infected, and they could die, and, you know? For me, there was just that acceptance of, I did it and I caused them pain, but if I don’t, they could get stuff, they could die. So what’s better? . . . the realization that, that, it’s something that had to be done, and somebody had to do it. Unfortunately, that responsibility falls on the nurse. —Participant 5

And: So, and this is just a few seconds compared to if I don’t do this, then you end up, you know, you end up dead, so that’s pretty much my concept. And I told my boys, think of that instead of um, hesitating to do something and in the long run being guilty as far as I should have done this to save him, or I should have done, you know, done that. —Participant 7

Nurses viewed carrying out procedures as a mandate with both meanings of the word: having an order (order here was used in a broad sense to mean an authoritative edict or adherence to established nursing standards of care) as well as the authority to carry out the procedure. Nurses appeared to be at least motivated in part by obedience as well as by being of service to patients; Participant 4 felt a sense of duty.

Carrying out procedures. I did not specifically ask the participating nurses to give an account of carrying out a procedure, and thus nurses spoke rarely about carrying out procedures in detail. This resulted in limited data. Participant 13 assessed the difficulty of a procedure and, if deemed necessary, would not hesitate to request assistance. Assistance,

however, was not available in all settings, and thus CIP could be viewed within the context of availability of resources (e.g., CIP is potentially an organizational issue).

Yeah, I'm like, 'Oh, gosh.' What I do is in the GI clinic. . . . First of all, if I look at your hands and I see a good, decent vein and I know I can hit it, I'm going to go for it. If I'm, if, I might try it or I'll get someone else if someone else is there who I know is better than I am. Like I said, I have ER background. We stick 18s in a lot of patients. So, I'm like, you know what, if I don't feel comfortable, I'm not going to stick you to fish around. —Participant 13

Participant 8, similar to many other participants, engaged verbally with patients before starting a procedure and sought, what can be construed to mean, consent.

On the nursing side, um, I did home care, um, which involved med/surg skills also, um, and as far as explaining to my patients, that, let's say I was about to do a Foley cath on somebody, that I told them that people say there might be discomfort, but, um, I'm not going to lie to you, it might be sore or it might be painful to you, but I also explained to them that this is really crucial that I do this. I will do this as most efficient and as accurate as possible so that the pain, if you are experiencing pain and not just discomfort, then, you know, I'll minimize the time, but I need to—I know you understand that we need to do this, and—whatchamacallit—and most of the time they said, 'Yeah, all right, go ahead and do this,' and then we do, we, we, we do it. —Participant 7

Responding to procedural difficulties. Procedural difficulties shed light on the complex dilemmas nurses faced when carrying out procedures and how nurses responded and found solutions. Participant 7 defined procedural difficulties within a personal context as an obstacle or hurdle to overcome. His remarks captured some of the anguish he experienced: Not only did he encounter procedural difficulties but he also made the patient cry. Despite his anguish, he defined the procedure as a success. I have explored “success” in more depth in the section *Accountable to Whom*.

I can still see that old man when I did my very first Foley outside of nursing school. That was, yeah, that was—it's as though I see his face, but yeah, I mean it was—I did it successfully, obviously, but he was, he was crying, so and being a new grad, to have to do that under supervision to get checked off, yeah, so actually that's pretty much it . . . Hesitating whether I should go with it, and yeah, I hesitated 'cuz I could

always just tell my, my preceptor, so to speak, which is a nurse that was kind of doing my orientation, that you know what, can't we just do it? But I told myself I need to pass this hurdle because eventually, I will encounter a similar, a similar patient that would present like this, too, so I need to get over this even though it was very difficult for me at that time to continue on. —Participant 7

It kind of reminds me that you'll encounter throughout your nursing career issues like that, situations like that. You just gotta go ahead and tell yourself, OK, this is an obstacle. Why did I get it, and how can I overcome it? And always, I always revert back to the fact that you've got to reassess; you've got to apply what you learned. —Participant 7

Participants 2 and 5 called their competence into question; their remarks further highlighted the perceived lack of resources and/or alternative approaches.

So, yeah, dressings, um, a lot of dressing changes that really just were extremely hard for me. I think it made me also feel not all that qualified. I think I really questioned my ability to change dressings well, you know, and that pain was a part of it. Because, um, I just felt like there has to be a better way. You know, there has to be a better dressing, or you know, what am I missing here that's, you know, that's still sticking really badly to the skin, or, who, or whatever. Or, maybe it should not even have had a dressing in the first place, and you know, people's skin are so fragile, and, um, you just know it's going to be really uncomfortable for them. —Participant 2

And: I wish that I didn't have to do it. I wish that there would be another way where we could, you know, a way to circumvent it. But, there's always that understanding, like if you're testing a little one for a UTI, the only way is to get a urine sample, and when they're that small, it can be difficult. If the baby is dehydrated and needs IV fluids, there's really not another way to get it done. —Participant 5

Difficulties during procedures tempted Participant 2 to rush a procedure. It was only her own personal restraint that prevented her from doing so.

I just felt sweat coming off, you know, I just felt like I was sweating and just wanted it to end so quickly. Yeah, there's always that temptation, you know, which I'd never, ever do, but just to do it fast and take it off, but—oh my gosh, I took breaks for him, because he was just moaning and in so much pain, I kinda said, 'OK,' and for me also, just to say, 'Oh my gosh, how much longer, you know, this has to end soon. I can't just keep doing this to this man.' —Participant 2

Participant 2 in the following clinical situation carried out a procedure to ease the burden of care for a wife in a home-hospice situation; the proposed procedure was not

indicated by the patient's medical condition. This remark highlighted the complexities of nurses' choices in which an intended "good" resulted in unnecessary CIP that Participant 2 found difficult to witness, and she subsequently called the procedure, inserting an indwelling Foley catheter, into question:

Feeling so concerned for the wife, who's only wanting to do something good to help him, and to prevent any accidents that could occur trying to get him out of bed. And I just, you know, I just kept looking at her, and saying, 'Do you want me to keep doing this?' And he was just going, you know, he kept pushing me away. He was kind of out, you know, kind of in another world at that point, but, it was just fascinating. I, who was I doing good for? I don't know who, if I was doing good for anybody. I, my hope was to do good for her [referring to the patient's wife], because she was just beyond exhausted from dealing with everything, and you know, so. —Participant 2

Nurses also reported finding solutions. Participant 4 did not to hesitate to ask the patient for assistance.

And, then we would explain why we had everything laid out, and for each one of the dressing sites . . . we would explain, um, what we were going to do, which one we were gonna do next. So, to have her help us do it. And she understood, because she had gone through not being able to be effectively treated when she was in, not the American Samoa but the other side. So, she had had a lot of pain with that.—
Participant 4

Participant 5 aborted any further attempts to complete a procedure.

Yeah, and I think I have more of a problem when I know that maybe it doesn't need to be done. Because I've noticed in the ER, the ER doctors, with your GI bleeds, they stick NG tubes down. Whereas in the ICU, that usually doesn't happen. So, these patients are awake and alert, they're feeling everything. In the back of my mind, I'm like, 'Do we really have to do this?' Because, if this patient were in the ICU, the doctors wouldn't be ordering this.

Even with, when they have esophageal varices, I know that NGs aren't strictly contraindicated, but there's that, is it really necessary? That to me does seem kind of silly. With those patients, I'll try, and if we don't get it right the first time, or if they start having too many issues with it, I'll just tell them, 'You know what? It's OK, we just won't worry about this.' —Participant 5

Participant 10 realized that there is no certainty in predicting a medical outcome for a patient and thus absolved herself from responsibility and referred the issue to a higher spiritual power.

So, there's always in the back of your mind, you don't control whether someone lives and dies. You—you just support them toward living. You know what I mean, so even with this guy that's 95 percent burned, I was pretty sure he was gonna die, but then the other part of me would say, 'You have seen, you know, the walking dead return to life, and you've seen people who never should have died turn around and die.' Who are you to decide? It's between that person's spirit and God. It's not yours. You don't know. —Participant 10

Participant 7 defined procedural difficulties within a personal context: an obstacle and a hurdle to overcome. Participants 2 and 5 called their competence into question. Participant 2 called the necessity of a procedure into question. Procedural difficulties highlighted the perceived lack of resources or alternatives. Procedural difficulties revealed “the temptation” to rush a procedure, which could result in suboptimal nursing care. Procedural difficulties also demonstrated that nurses found solutions. Participant 10 solved not knowing by surrendering to a higher authority, a religious context.

Nurses and Clinically Inflicted Pain

Intent and intention. Intent and intention did not emerge as significant within the coding phase. I specifically revisited the interviews to address the importance that Madjar (1998) placed on intention. “It is the nature of the social situation in which it [CIP] occurs, which requires both a therapeutic intent from the person inflicting the pain and active cooperation from the patient, that makes inflicted pain distinctive” (p. 158). In addition, intention was also important within a legal framework. A total of four nurses used the actual word intent or intention. The following comments from Participants 4 and 8 captured the meaning of intent as an inner, personal attitude of the nurse. Participants 4 and 8 happened to

have the longest work experience as nurses. I did not know whether this was coincidental and bore any significance.

But, if you do a procedure the best you know how, with the right intentions, and things go wrong, that doesn't mean you don't feel bad. You do feel bad, because, what are we about? We're about trying to help people. Right? Trying to provide, uh, services and health care interventions that are gonna make them better. —Participant 4

And: But, but, I do, clearly, because I keep saying that, you know, have a sense of, if I do whatever it is in the kindest way possible, with the greatest compassion, and the truest intent, and it actually, you know, kind of my best belief or understanding is that this will benefit this person. I'm willing to go through the situation of that person screaming at me, or, or whatever else it is. You know, although I don't like it at all. —Participant 8

And: You know, or if people do it with cruelty, and coldness, I get really upset, right? And you'd see that. That would happen a lot. When you're doing something horrible, that's done with the best intent, and with kindness, and with actually, reasonably, will, will be the best for the person, I think it's OK. You know, in my own system. I wouldn't have been able to stay in nursing, I guess, if I felt differently. —Participant 8

Intent was accompanied by adjectives such as “right,” “truest,” and “best.” Nurses also used the verbiage of intent to describe something that was beneficial for patients.

Participants 4 and 8 recognized the significance they themselves had on their conduct.

Participants 4, 9, and 13 used intent and intention in order to make their conduct acceptable and defensible as well as to illustrate a negative case:

You know, you try and explain it as much as you can, you know. This is why we have to do it this way. I'm really sorry, you know, and then sometimes just hold them down and do it. You know, it's mean. Yeah, I think you have to be in a way a little hard-hearted . . . it's not that I'm doing it intentionally You have to. Sometimes you do things that are gonna hurt, and you have to do them, and you know you just have to kind of suck it up and be the mean one for a little bit. —Participant 9

And: I wouldn't intentionally not do anything to harm another person unless there was a good reason for it, you know? I'm thinking back to my days before I went to nurse's school, giving those babies those shots in the leg, do you remember that? Two shots here, three shots here; that, now that was, that made me, I don't know, feel a little

empathy for the babies, but I don't know, it was for a good reason. They need those shots. They need their shots. —Participant 13

And: You don't cause them pain in any way. Um, so there's a moral compass in that. And like you don't intentionally hurt someone without having, you know, a procedure or something that you have to do; that's a very basic moral compass for me. — Participant 4

There was a defensive undertone in these comments; it appeared that the nurses were absolving their conduct by referring to the lack of intent/intention to hurt or harm. Participant 5 expressed a similar sentiment but referred to purpose.

But then, on the other hand, like you said, it's not . . . Yeah, we are going against what we've been taught: not to hurt people. But then, on the other hand, it's not for the purpose of causing pain. You know, it's not just to go hit somebody just to hurt them, kind of thing. But, in that way, the situation is different, because I don't hit my brother to make him better. I hit him just for the purpose of hurting him. But, whereas when I go to work, I am inflicting pain, but it is for a completely different purpose. — Participant 5

Mitigating and aggravating factors with regard to inflicting pain. Nurses, in general, expressed that they did not like inflicting pain on patients. The following series of mitigating and aggravating factors was compiled from the interviews. Inflicting pain was less problematic in cases of perceived necessity or urgency; when a nurse had good rapport with a patient; when nurses felt competent in carrying out a procedure; when a patient understood the indication for a procedure and was in agreement; and when a patient's wishes were known. Inflicting pain became more challenging and problematic when a first attempt in carrying out a procedure failed (such as with multiple attempts to start an IV access); when the duration of pain infliction was prolonged (e.g., a saline bath to treat burn injuries); when nurses were confronted by patients' expressions of negative reactions (physically or verbally); when the nurse perceived emotional (also referred to as psychic) pain, fear, or

anguish in patients; when children were involved; when patients' wishes were unknown; and most importantly, when the nurse projected medical futility.

Attributing significance versus priority. All nurses acknowledged inflicting pain; this acknowledgment attributed significance to CIP. Participant 4 described her observation of electroconvulsive therapy as “frickin barbaric.” She also described positive treatment outcomes (patients were no longer depressed). At another point during the interview, Participant 4 summed up her observation of children's reactions to vaccinations as, “Kids . . . always cry.” These comments, particularly with regard to childhood immunizations, illustrated how nurses acquiesced to CIP—and although CIP was important, it was not a priority within a broader context.

Well, if you don't believe it, it's hard to do it. I think. I don't think I've ever done anything to a patient that I didn't believe in. That's, I think that's a necessary first step. You have to believe that it's beneficial for a patient. I mean, even when I was, oh, this was really a long time ago. Um, I worked in a small, private psychiatric facility, and we had to do ECT train. . . . I actually helped with the ECT with the Brevitol and put the little paddles on the head, and you can see the patient twitch [inaudible] all around. When you see a patient go through those twitches from ECT, you wonder, ‘This is frickin' barbaric. I don't know if I, what the hell is this?’ But then you see them later, and their symptoms, and they're not as depressed, and they come out of it. It's like, we don't know how it works, but it works. —Participant 4

And: And kids, when you give them their vaccinations, they always cry. But, do we want kids to get measles, whooping cough, and all the other things? No, so, we give our, I take my own son in to get those shots. Because I know it's for his, his good. I don't want him to get polio. I don't want him to get all that stuff. And, uh, you know, if you're of the age that you can understand and not be so egocentric, you know, this is not about, just how it hurts. There's much more to this. —Participant 4

Viewing Clinically Inflicted Pain: Attitudes nurses brought to Clinically Inflicted Pain. For approximately half to two thirds of the nurses, CIP was not problematic. I arrived at the numbers half to two thirds because inflicting pain was problematic for some participants in selected circumstances but was not problematic in general. Participant 13

captured the attitude of nurses for whom CIP was not problematic by stating succinctly, “There was a good reason for it, and I think as a nurse, that’s why we’re doing this. We’re doing this to help this patient.” For approximately a third to half of the participating nurses, inflicting pain was problematic at least some of the time: Participant 2 spoke about wanting to leave the nursing profession; Participants 7, 8, and 10 spoke about leaving a certain specialty area; Participant 11 struggled to find meaning and expressed concern about not wanting to lose the “empathetic side”; and Participant 14 chose an administrative pathway.

It’s very clinical in this, in this, you know, what we call clinical in this sterile and removed. They really don’t talk to you as a person kind of thing. We are just an object, and, and these parts of your body are objects, and we’re going to objectify it and do this procedure. And I didn’t like how unholistic and almost disrespectful that seemed of the patients. I was always trying to like make that connection with the patients in a more personal way. —Participant 14

Participant 11 recounted a clinical situation on a burns unit: What had made her wanting to cry was exciting to her peers.

I kept thinking, ‘Well, I know these guys do feel pain,’ and when you have to clean, you’re scrubbing. And, you give them pain meds before, but, it still didn’t make me any more comfortable with it. I mean, I just wanted to cry. I was, I remember listening to another student talk about it, and she was so excited, and I just thought, ‘I just want to cry.’ —Participant 11

These findings raised the question of what differentiated the two groups. Participant 11’s attention was focused on the patient’s ability to feel pain: She had instituted pain-relieving measures prior to carrying out the procedure—yet remained uncomfortable while carrying out the procedure. Her focus of attention was foremost on the patient feeling pain. I deduced that nurses had a choice where to place their attention (i.e., what they considered to be most important). I wondered whether inflicting pain was by definition unacceptable or simply “wrong” for some nurses and whether I needed to view CIP within the context of

attitude. I defined attitude, based on Merriam Webster (2015), as a mental position with regard to a fact or state. I postulated that attitude toward CIP was something deeply personal, a basic premise that laid the foundation of a nurse's perception and approach to a clinical situation in which CIP took place. I went back to the data and searched for the word *attitude*. Only Participant 10 used the actual word; her use of *attitude* underscored its significance.

I think I was thinking more about her emotional state and that you can, again, you can damage that by your attitude and your handling of what's going on with the person's body. —Participant 10

The discovery of attitude was a major breakthrough in my thinking. Given that I did not pursue attitude in greater detail during the interviews, limited data were available to shed light on this finding.

Not knowing: The uncertainty of pain. Nurses could not feel the pain they inflicted.

When you're taking blood or giving a shot to a patient, of course you're not feeling it. You see the patient's reaction, I mean you don't feel the pain. —Participant 13

Participant 13 knew intellectually that the patient was the only person to know her or his pain yet doubted or even contradicted reports of pain; she concluded, "I don't know."

In the ER, we get those repeat, those what do we call those, frequent fliers. We get frequent fliers, and we know the ones that will fake, 'I've got a headache. This hurts and this hurts,' in order to get pain medication. And still for those patients, I am still, you know what, if this patient says they're in pain, they're in pain. I'm that type of person, but I don't know. You get a little numb to those patients at some point. —Participant 13

Within a clinical context, nurses needed to respond to complaints and expressions of pain. Which raised the question: How did a nurse respond to something that s/he could not know with certainty?

Filling the gap and attributing meaning to Clinically Inflicting Pain. Nurses witnessed the effects of their actions when carrying out a procedure. I purposefully used

clinical language to highlight a procedural approach and viewed the clinical situation from the nurses' point of view. Patients displayed the following indicators: (a) visual (grimacing, crying, etc.); (b) auditory (moaning, screaming, becoming silent, etc.); and (c) tactile resistance, (tensing up or withdrawing, etc.). Some nurses referred to an additional sense (or different way of knowing) best captured as an emotional connection (or intuitive knowing, for lack of a better word). It appeared most likely that these nurses responded to the emotional anguish and suffering experienced by patients, not to the sensory experience of pain itself. Despite knowing that only patients knew the extent of their pain, nurses somehow arrived at an estimation of painfulness, using qualifiers such as “mild pain . . . somewhat painful . . . very painful . . . extreme pain.”

But trying to think of when a patient had like severe pain, and I notice the hip fractures, they were very painful for the elderly people. Uh, any type of surgery that's not going to be general anesthesia is going to be somewhat painful. —Participant 6

And: And what I'm realizing is, this depends so much on the particular nurse and the particular job. Like say, I had been trapped in ICU for 30 years, you'd probably be getting stories from me of how much I hate working there, right? And it sounds, so if you take people that are doing extreme jobs, causing extreme pain, and maybe, maybe for this, you almost, I mean, this is just a thought for you, you need to narrow it down to people doing jobs where they're causing extreme pain, rather than mild pain in people that are going to be fine. Right? It's totally different, the impact it has. But, but to cause that type of pain, and if that, I bet you anything that person empathes the pain, right? —Participant 8

And: But, I'm trying to think of other times inflicting pain. I think the other times inflicting pain, I mean the NG tube, I don't think putting in Foley's is that painful. I think it is just uncomfortable for people, embarrassing for them. Although, once I had a real hard time getting it in on a man, but I tried twice and then I, you know, I—I had them call the urologist. . . . I am trying to think of other things that I've done that were painful. I guess irrigating wounds, wound care. I guess wound care would be something reasonably painful for people. —Participant 10

Participant 10 used the word “reasonable” to describe pain. *Reasonable* is an adjective more commonly used to describe a mental activity. Pain, however, is a sensory

experience that nurses lack when carrying out procedures. Nurses faced a gap; they saw expressions suggestive of pain, yet they did not feel the pain they inflicted. In an earlier section, I revealed the constructed nature of CIP and the constructed nature of the estimation of its painfulness. Within this context, I demonstrated that the construction of CIP and its painfulness served a purpose: that of filling the gap when faced with the reality of inflicting pain yet not knowing the extent of the pain and being obliged to respond. If nurses constructed CIP and its painfulness, it followed that nurses also denied the existence of pain. Participant 13 carried out a procedure in which she inserted a nasogastric tube into a patient's nose; she duly noticed resistance and concluded, "It's not really painful."

It's not so much painful as I guess it's because you're putting something in someone's nose, yeah, like what do I? Don't put a tube up my nose. So yeah, they'll fight you, but it's not really painful. I mean, my take on it is it's not painful. . . . The most painful procedure will likely be an IV if you don't know what you're doing. — Participant 13

Participant 13 offered a clear description of what constituted "the most painful procedure . . . will likely be an IV;" any other procedure was, by definition, not (that) painful. The observed resistance was explained as being caused by a nuisance (a tube in the nose), not by pain. Although it is possible that an NG tube insertion may not be painful, a Google search indicated a large body of literature to the contrary. My point, however, was not to say the nurse was inaccurate in her interpretation; my point, within this context, is that Participant 13 interpreted her observations (resistance, in this case) to mean there was no pain and thus constructed her estimation of its painfulness. She did so to make sense of her observations and to proceed with the procedure. As such, constructing painfulness served a purpose. The constructed nature of CIP painfulness also was evidenced by the discomfort

nurses ascribed to procedures, even when a patient clearly denied pain or did not show signs suggestive of pain.

I remember being so shocked, looking at her foot, thinking, ‘Oh, my god, this must hurt so bad.’ And, as I was cleaning it, I just, I couldn’t stop shaking. Even though the patient swore she could not feel anything. But I just remember thinking, ‘This has to hurt. This can’t be pleasant. This...’ I mean, even just watching it. It, you know, for me, it was traumatizing. —Participant 11

And: I think it affected me more than the kid and the parent, although I knew the kid wasn’t experiencing pain, because I mean, I was inserting that needle and giving the antibiotics, and the kid was just, you know, not even cringing, so I knew the pain med was working. —Participant 7

As shown earlier, nurses described the same procedure with different attributes according to the clinical situation in which CIP took place. Inflicting pain was considered right for a patient deemed likely to recover (thus justifiable) but became “wrong,” “pointless,” and “harmful” (Participant 8) in the case of projected medical futility. Participant 8 “[felt] good” about “intubating” a patient in a clinical situation where the procedure was viewed as lifesaving, but was “not willing to participate in harm that, that brings no good.” Clearly, she attached very different meanings to the same procedure. This showed that nurses attributed meaning to procedures that was independent from the actual procedure.

So somebody comes in, and we’re intubating them, and they’re fighting and struggling, and we’re tying them down, and we’re giving them drugs, and they’re scared, and they’re fighting, and things hurt. You know, we’re putting lines in, and we’re, you know, he’s tied to the bed on a ventilator, which I think is a horrible experience, you know. The, um, if they, there’s every reason to think that they’re going to have a good outcome, it’s like, I feel good about doing that. —Participant 8

As opposed to:

I realized that there are all these different categories. It’s like it’s not, um, it’s almost like doing that which is hurtful, when there’s no hope of good outcome for the patient, is more what’s at issue. You know, in terms of feeling bad about it myself.

When I feel bad about causing harm, it's like, say, we have an 88-year-old grandma on the ventilator with end-stage lung disease, or she has a big stroke, and this family can't let go. Right? And, then, we're torturing that woman because everything we do has no hope of good outcome for her. That makes, that just upsets me. It would upset me so much. . . . I'm not willing to participate in harm that, that brings no good. — Participant 8

Transforming Clinically Inflicted Pain: The unmaking of the patient's

experience and the remaking of Clinically Inflicted Pain. The following comment was a response by Participant 3 to my inquiry about the discomfort and distress that patients reported to me (as their primary care provider) regarding intramuscular injections of extended-release medications. Participant 3 has administered these injections.

I think, in regards to the treatment, it really depends on, you know, how they feel, how they think, and what their quality of life is in relation to getting the medication. Although it is an unpleasant experience, I mean I don't know what is worse, whether suffering with different mental illnesses and symptoms, you know, is more painful than taking a shot and being medically compliant. —Participant 3

Participant 3 rightfully pointed out that it was the patient's experience that should matter most. He then related his interpretation of CIP as “an unpleasant experience” and launched into the broader issue of “suffering with mental illness and . . . being medically compliant” — neither captured CIP. I argued that by referring to CIP as an “unpleasant experience,” the nurse was unmaking the patient's experience of pain. I further argued that by placing CIP in a different context (mental illness and compliance), the nurse was effectively remaking CIP into something other than pain. Typically, nurses did so by placing CIP in a context that was pertinent to nurses' work or considered a desirable outcome.

Using Clinically Inflicted Pain. I postulated earlier that CIP was an important feedback mechanism that nurses utilized to assess how well a procedure was progressing (e.g., to detect if a procedure was going as planned or whether the CIP was suggestive of

possible complications). Thus, CIP was a tool for nurses. On the premise that CIP was a clinical tool, it followed that nurses became self-proclaimed experts. CIP as a clinical tool was not an obvious finding in the interviews. CIP as a clinical tool was noted in Madjar's (1998) study (although Madjar did not describe it as such). In one comment, a nurse in a burns unit used CIP to assess the viability of tissue. Another example of CIP as a clinical tool is the Glasgow Coma Scale, which specifically uses painful stimuli to assess a patient's response and draw conclusions about the neurological assessment pertinent to this patient. From this and previous sections, I concluded that CIP was a phenomenon that nurses use, construct, and control.

Making it right: Justifying Clinically Inflicted Pain and passing judgment. There is a difference between what is legitimate and what is right, evidenced by moral dilemmas. Providers' orders legitimize procedures. Legitimacy by itself was insufficient for some nurses, and these nurses justified carrying out procedures by establishing the rightfulness of a procedure. Nurses established rightfulness on the basis of: the medical indications for a procedure; the broader context of a patient's life; the patient's consent; and the projected medical outcome. Nurses struggled to carry out procedures in cases of projected medical futility.

So—so the dilemma for me wasn't so much coming from the authority telling me what to do; it was coming in and out of a situation where I didn't have the knowledge of whether or not this patient would have wanted us to do what we were doing. . . . You really have to have two elements, it has to be the right thing to do [medical indication], and it needs to be right for that person. That person has to have some consent. —Participant 10

Several nurses could not recall carrying out a procedure that went against what they believed to be *right*.

Well, if you don't believe it, it's hard to do it. I think, I don't think I've ever done anything to a patient that I didn't believe in. That's, I think that's a necessary first step. You have to believe that it's beneficial for a patient. —Participant 4

I haven't had a real specific scenario-situation that would, um, go against what I believe. —Participant 7

And: Interviewer: It becomes a different story once the nurses don't believe in what they're doing.

Interviewee: I don't know that I've come up in that situation much. I mean, I can't think of any off the top of my head where I don't believe. —Participant 9

And: And I think in this case—so in this case it was one—it was—so I—I—you know I obviously was—we were told to do this, right. So, on some level we had an order, but for me it wasn't so—what was harder for me, I'm trying to think, 'Was I ever told to do something that I absolutely believed was wrong.' Probably not. . . . I think ultimately, you have to believe in what you're doing is helpful for the patient. Otherwise, how can you do it? You, if you're questioning it, you know, I think you're obligated to get more information about it. —Participant 10

I postulated that establishing rightfulness must therefore also be reflected in nurses' conduct. Several participants (4, 10, 12, and 13) established rightfulness by seeking additional information or clarifying orders with providers:

Well, first of all, when I was first assigned her, you get a report on her, and I was asking a lot of questions. . . . Well, it's gathering information that's needed to help the patient be better, feel better, and get healthier. I mean, it's part of a process. It's a necessary, maybe unpleasant step, but it's a necessary step, and if the clinician understands that it's a greater good to gather this information, so that you can effectively treat the patient, why would you not do it? —Participant 4

I viewed establishing rightfulness as a subjective appraisal of a clinical situation.

Establishing rightfulness appeared to be a complex response pattern and provided the justification to carry out painful procedures. Only two nurses used intent as a measure for justification. Justification, although based on available evidence, was a subjective measure.

Nurses assumed a position of authority, as noted earlier in this chapter. Nurses justified carrying out procedures. Justification was accomplished by a review process, and

upon completion of this review process, nurses made a decision and passed a judgment whether to carry out or abort a procedure. I chose the term *passing judgment* to highlight the binding nature of this decision. It was striking to note that nurses claimed they did not carry out procedures that they did not believe to be *right*. The review and decision-making process that led to passing judgment also established what a prudent nurse would do in a given clinical situation and as such has broader applications than a mere decision-making process. By using the terminology of *passing judgment*, I wanted to call attention to the significance this decision-making process had for nurses; it figuratively became the law as nurses were obliged to carry out or abort procedures. I also wanted to call attention to the potential judicial implications of this decision-making process.

I conclude this section with an example of the review and decision-making process in which Participant 10 passed judgment in order to provide care to a patient under her care. She not only doubted the benefits of continued care but expressed and knew that providing care could likely result in pain (without the benefit of recovery).

And I think that when the circumstances are most clear and it's most clear that you are doing it for a good reason, it's less difficult, but I think it's still difficult to inflict pain on someone else. So, even—I think it is—so I think—when you—like the man that—the man that was 95 percent burned, in my heart I was pretty sure he would die. You know, all the statistics said that he just had too much burned. So, part of me said, keep him comfortable and let him go. You know what I mean? Why are we doing this? Why are we prolonging and giving him weeks of agony when it is very, very likely he's gonna die. On the other hand, for his sake and the sake of his family, you know, he may have very well want to live for his family and try to live and do what he could to live. That certainly has to be honored. But, I think when it is less clear like that and then you're, you know, kind of causing this terrible pain when the outcome is probably [background noise] going to be death and all you're doing is prolonging his life in pain, I think then that for me gets to the territory of what am I participating in and is this right. And also, you know, and now part of it was that I came into this as a float. I had not met the family. I didn't have enough history to know, and that particular night his blood pressure was very low so he was not very, you know, he himself was not very with it. But I think not having the full story, like if

they'd said he came in and he said, 'I've gotta live for my family, you know, do whatever you need to do.' it would have been easier for me, but I didn't know what if he had ever participated in this decision of keeping him alive. If he had ever consciously participated in it. Do you know what I mean? . . . Um, and—and that surreal quality and—I suppose not having a context or a story or truly knowing whether this—this man wanted us to do what we were doing. In a sense that was a moral dilemma. —Participant 10

This comment showed that the review and decision making process was independent from the nurse's preferences and beliefs. Provider orders or adherence to standards of care were not specifically mentioned and appeared not to be part of her review process. Participant 10 described uncertainty and an emotional conflict; she passed judgment in order to provide care for this patient and her decision was binding.

Asserting authority. Nurses assumed authority when carrying out procedures by filling the gap and making it right. Nurses appeared to objectify subjective conclusions, which added another layer of authority.

Nurses Were Affected by Clinically Inflicted Pain and Responded

Responding physically to Clinically Inflicted Pain. Three participants reported physical symptoms while carrying out painful procedures. Participant 2 said, "I just felt sweat coming off, you know . . . And I could just feel my, you know, heartbeat, you know, raising." Participant 11 said, "I just, I couldn't stop shaking," and Participant 6 said, "I think it's, it's bothering me. It's, maybe my heart rate is increasing, and I become more tense." Although one of these nurses was a recent graduate, the other two nurses had many years of experience. It was not known why only three nurses reported physical symptoms. I viewed the reported physical responses as indicative of the stress experienced by these nurses.

Responding emotionally to Clinically Inflicted Pain. Inflicting pain was problematic to some, but not all, nurses. For approximately half to two-thirds of the

interviewed nurses, inflicting pain was neither stressful nor problematic; these nurses came across as neutral.

For me, I have never really had any issues with that with administering or, um, um, doing a dressing change or whatever it is that I want to do, insert a Foley, if there is pain. I will always try to address it beforehand so we have the least amount of pain occur and we have the best-case scenario happen. That's how I've always practiced as a nurse, myself. —Participant 12

And: It's funny because my whole, my whole nursing career, and even doing things that hurt people, I've never had this sense of, it's a problem because I was told that I shouldn't hurt people. This would just have to do with how we are individually trained. —Participant 8

For approximately a third to half of the nurses, inflicting pain was, at least at times, distressing. There was not one particular comment that captured the differences between the two groups. The differences were evidenced by the flow of the interviews: The neutral group typically indicated they had no problem and were struggling to understand my questions; the other group was eager to talk. I did not know for certain what accounted for the difference between the two groups and postulated in an earlier section that attitude toward inflicting pain could have played a role. I further noticed some form of personal involvement in the group that appeared to be emotionally affected; these nurses appeared to allow themselves to be touched by what they witnessed.

But then on some level, you know, what—the fact—I guess what it is, is that the patients that stay with you, like that child or like that elderly man or, you know, like that—that burn patient that had 95 percent of his body burned, those for me clearly I have some moral injury then there because I—they have stayed with me and there is still pain when I think of that. . . . So, for me, he was this pink body in a bed. You know, just pink and red, raw body in a bed and with a face that was red and raw, you know, with an EG tube in. You could see him just—you could see the pain on his face. He couldn't express it. He couldn't talk. —Participant 10

There seemed to be triggers for emotional responses, such as moaning, grimacing, or caring for a child.

I took breaks for him, because he was just moaning and in so much pain. I kinda said, ‘OK,’ and for me also, just to say, ‘Oh my gosh, how much longer, you know, this has to end soon. I can’t just keep doing this to this man.’ —Participant 2

In the following comments, Participant 8 responded to the emotional state of patients.

People doing jobs where they’re causing extreme pain, rather than mild pain in people that are going to be fine . . . It’s totally different, the impact it has. But, but to cause that type of pain, and if that, I bet you anything that person empathes the pain, right? She’s somebody who, who feels that person’s pain. And remember, I said, I can’t stand, I can’t stand doing strokes and quads. I mean, there’s some quads that are fine. I mean, they just are people who just, they can handle it, right, and stay positive. But, I can’t handle other people’s despair and pain when it goes beyond, see, this is a whole different take. When that pain goes beyond a certain level of severe darkness, severe depression, severe pain, you know, severe despair, and your burn people are in that category. And if I was being a burn nurse, you would be getting a lot of that type of response out of me, too. —Participant 8

And:

And then you’re talking about severe emotional pain and despair, and distraught, and being a person, in effect, being the torturer, right, for that person who can’t even see anything beyond my torturer just showing up every day. I mean, this is like Dante’s inferno-kind of stuff. When you talk about being a nurse in a burn unit with that type of pain and despair that goes on, seemingly without end. So, that’s where, you know, you really can get into the powerful archetypes and mythos, and it’s not just the physical, it’s like, causing that type of emotional distress. Darkness, and oh my god, the anguish, the personal, the way it plays on the personal, the nurse’s personal stuff, the patient’s personal, all that stuff. You know. —Participant 8

Participant 10 said that inflicting pain “costs you something emotionally.” Participant 5 referred to an emotional burden, and Participant 11 recounted asking questions as a nursing student—and receiving unsatisfactory answers from her nursing instructor.

Um, I think there are, well I think that there is a natural, aversion to inflicting any kind of a pain on another human being and particularly on a child. And when you do have to do something as a nurse that does call for that, I think that that, um, that costs you something emotionally. And I think that when the circumstances are most clear and it’s most clear that you are doing it for a good reason, it’s less difficult, but I think it’s still difficult to inflict pain on someone else. —Participant 10

And: I think that you do have that tendency to shut emotional things off within you, I think, when you go to work. Because, in a lot of ways, you kind of have to, to be OK. Especially in the ICU with everything that you see and that you do, you can’t It’s

too heavy to carry that emotional burden. So, I think that we do turn a lot of that off when we go to work. —Participant 5

And: I don't want to be that mean nurse. I want to provide good care to my patients. But, how do you provide the necessary care without hurting them? Without causing them pain, or making them afraid of you? How do you do that? And my teacher said, 'You suck it up and become tough.' You know, it's just like, 'Uh, that's not an answer.' —Participant 11

Different response patterns such as (emotionally) disengaging also were noted.

That's, I think, that's one of the things that I learned throughout my nursing is you need to sometimes compartmentalize your emotions and just be the nurse that they need you to be unless I know for a fact that it was totally against, I mean totally go against, my whole belief system, so to speak. —Participant 7

And: You know, you try and explain it as much as you can, you know, this is why we have to do it this way, I'm really sorry, you know, and then sometimes just hold them down and do it. You know, it's mean. Yeah, I think you have to be in a way a little hard-hearted. . . It's not that I'm doing it intentionally. . . . You have to. Sometimes you do things that are gonna hurt, and you have to do them, and you know you just have to kind of suck it up and be the mean one for a little bit. —Participant 9

From these reports, it was evident that nurses used a variety of strategies, one of which was disengaging. Participant 5 reported “shut[ing] emotional things off within you”; Participant 7 reported “compartmentalize your emotions”; and Participant 9 “suck[ed] it up.” Emotional disengaging was intended to lessen the impact of what nurses experienced within the context of CIP.

Empathy and sympathy. Seven nurses used the words empathy or sympathy.

Participant 10 emphasized an “emotional connection” with patients but did not use the words empathy or sympathy. Empathy was used as an adjective, a noun, and, on one occasion, as a verb. Empathy was used frequently within a feeling context, such as I feel empathetic, I feel more empathic, I feel a little empathy. Empathy was noted as something that can be lost and possibly can be developed.

I bet you anything that person empathes the pain, right? —Participant 8

And: Well, in some ways, yeah. For me, um, I mean, on one hand, I think what they're talking about is, when you're doing something to somebody who's screaming and crying and raging at you and thinking you're horrible, and you're hurting them, which can be a child, a demented person, or a normal-state-of-consciousness person, who is temporarily out of their mind. It affects me in any of those. I'll get really upset if the patient is really, really upset. You know. But what, what, because I'm extremely, I'm hypersensitive, and I'm very empathic, so I feel that. —Participant 8

And: I think that's one of my biggest fears is, as time goes by, will I forget why I originally wanted to be a nurse? I see it so often in the nurses that have been in the field for over 10 years. It's like that empathy that they once had toward their patients is gone. Some of them are either just burnt out, it's a bad season in life, or whatever's going on, but their empathy towards their patients is not what it used to be. —Participant 11

And: I don't want to lose that empathetic side. I never want to get to a point where it's like, 'Ugh, it's another day of work,' and I forget that the person I'm treating, they're a human being, with emotions, and just their own set of cares, their own set of concerns . . . It's so much easier to do a procedure with a person that, you know, you can sit there and talk with them through it. And they're not mad at you, you're not frustrated, you know. . . . It helps to build trust. . . . If I wasn't so empathetic towards my patients, I wouldn't care so much about the job I do. I wouldn't put as much concern into, 'Am I doing such a good job?' . . . I look at it as, if I wasn't so empathetic towards my patients, I wouldn't care so much about the job I do. I wouldn't put as much concern into, 'Am I doing such a good job?' —Participant 11

And: But I notice that health care, it seems, and well, in acute care, you're moving more towards an empathetic, um, way of taking care of patients. —Participant 12

And: There needs to be a lot more education on, on pain, and there needs to be more empathy. —Participant 12

Four nurses used the word sympathy. Participant 9 explained,

I think of sympathy as feeling for someone and empathy feeling with someone. Um, and I can think of a couple of times where I have felt like, oh, yeah, I feel more empathic. More of like, 'Oh, honey, I am so sorry, uh.' And I am not sure that it would make that much of a difference in my behavior. Number one, I'm still either way apologizing profusely for causing pain and, um, I think it's just in some [bird chirping] really in some kids you just have a different relationship with others. Some kids you feel closer and you just have a more feeling of just general friendship than other kids where you're just like you're their nurse. —Participant 9

And: So, when I give a shot, sometimes it feels like I'm giving myself a shot, because it's, I sympathize for my patients. It just, it, it kind of breaks my heart. Because it, I don't know, it's just, it's part of routine nursing. But it's just, it's the uncomfortable side of it. —Participant 11

And: So to be honest, I didn't have a lot of sympathy for him versus an elderly woman who is frail and fractured her hip. —Participant 6

And: Then, those were the times when I, like, 'Off, I mean, I cannot get out of this. I have an order to do this.' Um, but part of me, that, that's one answer, but the other part is when I go in there and do something and I am sympathetic, which, um, kind of allow myself to kind of be present and hear that other person. It, I've thought about it, aren't we sacrificing, kind of, our own sanity and well being for a higher purpose. I mean, to serve, basically, to serve other people. Um, that's kind of where I'm at, kind of, with the, with my latest thinking. But, it so raises the question: What does that leave for us? —Participant 2

I wanted to include Participant 10, even though she did not use empathy and/or sympathy but spoke of an emotional connection. An emotional connection served to lessen the “invasion . . . of [patients'] personal space.”

The reason I got into nursing was that connection. And so, and that's, I think, why also for me understanding the person's emotional state and connecting to them on some level and on some level having their participation and their permission to do what I was doing made those things then less of an invasion and less of a—maybe that's why I didn't feel like I was invading their personal space 'cuz I had created a personal relationship with them. —Participant 10

Participant 11 talked about “that therapeutic relationship” that allowed her to carry out her work more effectively:

Because, I look at when you care for a patient, how can you truly know what's going on with them, if you don't have that relationship. A lot of times when you first, and I know I struggled with this as a student, was, building that therapeutic relationship with my patients. That was something I always was so afraid of, in the beginning was, 'Oh my gosh, I have to go in and touch a patient.' And I remember the patients that I was able to get along with really easily were the patients that I would spend more time with them. I took extra care for them. And I realized, if I had that with every single patient that I cared for, you know, walking in the room, I can clearly see, alright, something's not right with my patient, what's going on? Or, just talking them through whatever it is that they're going through. —Participant 11

Getting emotionally involved meant that the nurse felt pain.

Interviewee: I left in intensive care, is that I realized that I couldn't find the middle ground. I—I—I finally came to the conclusion that you either were going to be present emotionally and go through the pain with the patient and the family, or you weren't. But there was no way to go halfway in and halfway out. You know what I mean? —Participant 10

Interviewer: Uh, not exactly sure to be honest.

Interviewee: Well, you were either going to create a personal relationship with that patient and with that family in which you cared about what happened and therefore the pain that they were going through you felt with them. —Participant 10

Participant 10 remembered how a show of emotions was discouraged in the nursing discourse years ago:

But because I—I'm a people person, I think that I realized that that would not—that would not be satisfying. For me, it's not, there's the intellectual challenge of the medical question, but for me it's really the person who has a story, and part of that story is the medical question. And I'm more interested in the person and their story as well as the medical question. So, I think I realized that I would have to, but I also think that I realized that I could never—I could not do intensive care for my whole life and that when I had children or someone to come home to, that I needed to have more emotional energy for, that that would be time for me to leave intensive care because I didn't think I could do both well. So, but I think, um, I think, for me it—I was aware of the choice I was making to engage, but I was also aware that that meant that I would at times be devastated or be, you know and also, I mean, I don't know if you remember in the old years they told you don't hug patients, don't hug families, never cry, don't show emotion. —Participant 10

And: You know, I learned pretty quickly that I broke all of those rules. I mean, you know, I hugged families and I cried with them, you know, and I cried with patients and sat with them. You know, and I realized that that I couldn't agree with those rules of nursing that you were supposed to somehow come in in your perfect white starched outfit and be this kind of tower of strength, which meant you were nonemotional. And then, when I first realized that I was—that, you know, it was OK to be emotional, then I think I was like, oh, well maybe I shouldn't do this. Like all that—that stuff from the teaching side came up like, you know, because they said things like your patient needs to know they can depend on you and you can't break down in front of them. But then I realized that by not breaking down, not that you should run in there and cry at every opportunity, but that when there was truly something that was very emotionally moving, to not be moved by that wasn't strength. But, um, and I don't know what—I don't think they teach that today that you can never show emotion, but

I remember that a little bit being part of my training. And there were still nurses that kind of held to that, but I think that, um, I don't know, I think for me certainly it was more satisfying as a nurse to connect to people. —Participant 10

And: That's, I think that's one of the things that I learned throughout my nursing is you need to sometimes compartmentalize your emotions and just be as a nurse that they need you to be unless I know for a fact that it was totally against, I mean totally go against, my whole belief system, so to speak. —Participant 7

I postulated, based on the above comments that empathy and sympathy were more than a feeling or response; empathy and sympathy appeared also to be an attitude that nurses bring to clinical situations. Empathy and sympathy served a purpose for the nurses who utilized this feeling, connection, approach, or attitude. It became clear that by choosing to connect, the nurse was more likely to experience pain. Compartmentalizing or turning off emotionally thus appeared to be a coherent emotional response. Participant 10 described a nursing discourse that discouraged emotional engagement and viewed being emotional as juxtaposed to strength. Yet, the nurses who talked about empathy and sympathy seemed to derive some form of reward (satisfaction) from engaging and expressed concern about the possibility of losing empathy. Not only did it appear that empathy could be lost but it also appeared that empathy could be developed. What, then, was empathy? What place did it have in nursing practice? Participant 10 indicated that empathy was chosen or abandoned. There were consequences associated with empathy, such as being uncomfortable and feeling pain. Empathy appeared to give meaning to nurses' work. Empathy also was noted as an entity that had the power to break a nursing discourse that encouraged nurses to "toughen up." I postulated that empathy could be the problem as well as be the solution; for example, a procedure carried out with empathy took on a very different meaning for nurses (and perhaps for patients), in which a potentially injurious act became a tool to facilitate healing. How

could nurses learn this emotional dimension of their work? Jean Watson's Caritas (2008) model comes to mind in which nurses are encouraged to take care of themselves in order to provide care to patients.

Cognitive responses: Transforming Clinically Inflicted Pain. In an earlier section of this chapter, I addressed the unmaking of the patient's experience and the remaking of CIP under the broader heading of Transforming CIP. Given the significance I attributed to these processes, I want to revisit these processes.

The unmaking of the patient's experience of Clinically Inflicted Pain. As mentioned before, CIP cannot be experienced by nurses directly. However, nurses saw, heard, and felt responses of patients that were suggestive of pain, and emotional responses of patients were at least as important for some, but not all, nurses. Nurses somehow had to make sense of these expressions while carrying out procedures (e.g., was the procedure going as planned? Were there complications? Did the nurse need to stop the procedure?). Making sense out of something (CIP that could not be experienced by the observer/nurse) had to be by its very nature an interpretation. In the next quotation, Participant 3 recognized expressions as suggestive of pain. The then-student nurse attempted to explain the etiology of the pain: He weighed the actual procedure in progress (rectal disimpaction) against the underlying condition (constipation)—this could be viewed as clinical reasoning, yet I viewed the coming to a conclusion as an interpretation (as more clearly demonstrated by Participant 13).

He [the patient] had verbalized that he was feeling some discomfort at that time [while disimpaction was in progress]. And he just gave facial expressions; he was grimacing on his facial expression, but it was hard to tell if it was just because of the procedure or if there was a result of his constipation. —Participant 3

In a different clinical situation, Participant 13 described the placement of a nasogastric tube. In this scenario, the nurse was encountering tactile feedback (resistance) and concluded, “It’s not painful.” In both, clinical situation signs suggestive of pain were present while a procedure was carried out; these signs were duly noticed and explained to mean something other than pain. In the first comment, the etiology of discomfort was questioned; in the second comment, CIP was simply denied. These were examples of what I called the unmaking of the patient’s experience of CIP.

Madjar (1998) pointed to assumptions nurses made about CIP. The presence of assumptions was supported by Participant 12’s observation in her capacity as a nurse manager: “And so I, um, what I discovered was they [nurses] didn’t ask a lot of questions. They assumed a lot.” Nurses defined CIP as “temporary” [Participant 13] and projected that patients will forget about it [Participant 13]. I argued that these attributes were not mere assumptions but examples of the unmaking of the patient’s experience of CIP.

The remaking of Clinically Inflicted Pain. Nurses unmade the patient’s experience of CIP, as shown above. This left a gap. The unmaking of the patient’s experience was only a statement of what was not there—but what was there? Given the unmaking of the patient’s experience I postulated that the answer to this question had to be something different than an observable patient response. Nurses filled this gap by substituting CIP with something they knew or considered important or desirable. These replacements were what I called the remaking of CIP. Within the remaking process, CIP became to mean something other than pain. The remaking of CIP was subtle: CIP became something that was “gonna help you heal” [Participant 4]. Nurses drew conclusion “kinda like the end justifies the means, to a certain extent, not absolutely, but relatively” [Participant 8], etc. The remaking appeared to

define CIP by its intended purpose, justification or as something nurses knew, intended, or aimed for.

Well, again, for me, if I'm causing pain, and I educate both the patient and family, and tell them it's for a greater good, i.e., this is gonna help you heal, or give us information we need, I'm not in conflict. —Participant 4

And: The way that I view it is that I am inflicting pain on these patients, but there's a very good reason for it, and it's actually for their benefit. It's where the benefits outweigh the risks. It's to help them, and to help make them better. —Participant 5

And: The, um, it's like the, the needed pain to get to a goal, as it were. So, there's no intention of harm, you know, so it's not pain that has been intended to harm, it's pain that's like a necessary part of getting to the goal of healing. You know, so it's like, um, it's kind of like a give and take, it's like, OK, to provide, you know, antibiotics, or to provide medicines, or to provide, you know, a ventilator to save someone's life. —Participant 8

The unmaking of the patient's experience of CIP was a process; the remaking of CIP was the result of this process. Unmaking captured the how, and remaking captured the product (results).

Adjusting

A number of strategies were utilized by nurses in response to CIP, including engaging in prayer or silently chanting. Nurses realized that by alleviating the discomfort for patients, they were able to alleviate their own discomfort. Participant 7 applied what he had learned while serving in the military:

So you just, OK, one, you gotta train; and two, you gotta train, and three, you gotta train, which means you practice, you practice, you practice. You build up their confidence, so similarly, it's like, for me in nursing school, every time I had a hard time, um, with certain things, I always tell myself what, what is the reason why I'm having a hard time? Is it this or is it that? And then based on what I've identified, OK, what are some of my courses of action that I could do so I can get over that so it's not hard for me anymore? —Participant 7

A separate strategy consisted of seeking peer support.

Hearing his moaning, realizing that I'm not even anywhere near finished with taking this bandage off, you know, I remember having to cut it, just get up, and stretch a little bit, walk to the other room, and just kinda go, 'Oh my gosh.' and I don't remember if I'd, on that trip or not, or on that visit, if I actually made a phone call to, like the nurse in the office, and said, and I did that on occasion, like a triage nurse in the office and said, 'You know, this is what I'm dealing with. I just, I don't know what to do. You know, he's in horrible pain.' —Participant 2

Nurses changed over time. I let the nurses speak for themselves.

I think you do get a little jaded. Not because you want to or you choose to. But, I think it happens. My kids have come to me with a bleeding finger, or a bleeding tongue. It's like, 'OK, you're not dying, wash it with soap and put a Band-Aid on it. You'll be OK.' [laughter] . . . I don't even know that it's, I don't even know that we realize that it happens to us. I don't think there was ever a point in time where I could say, 'I used to care a lot more here, and maybe not as much here.' I think maybe sometimes it's a gradual process, so that maybe we don't even realize that it's happening to us. —Participant 5

And: [Referring to work in an ICU setting]: Because I would get mean myself. You know, that, that's kind of a different piece. But I ultimately decided I'm not willing to work in a place where I have to do this most of the time, where I do not feel good about doing this. —Participant 8

And: I mean, I always think, I don't want to be that nurse. I don't want to lose that empathetic side. I never want to get to a point where it's like, 'Ugh, it's another day of work,' and I forget that the person I'm treating, they're a human being, with emotions, and just their own set of cares, their own set of concerns, and . . . I never want to be considered, like, who's that nurse, Nurse Hatchet. Isn't that the nurse? —Participant 11

And: From what I am seeing, the newer nurses are more empathetic, but it seems that as you get older, you lose that. Because you become thick-skinned, right? Because you can't let it affect your whole day. If you have a code in the middle of your day, and you still have six more hours, how are you going to function and take care of your other five patients, right? —Participant 12

Two things appeared noteworthy. First, Participant 5 noted that change was a gradual process that went unnoticed until "it" becomes obvious. There was the potential to become mean, as noted by Participant 8. Participant 12 described becoming "thick-skinned" and

“losing empathy”; however, empathy was also potentially problematic for Participant 12.

Secondly, change appeared to be optional. Participant 8 chose to leave a work environment in order to remain who she wanted to be: an empathetic nurse-person. I postulated that nurses were driven by a sense of preserving something unique and personal (possibly empathy), and that self-preservation drove nurses to become “thick-skinned.”

Choosing conduct: Setting oneself apart. Nurses distinguished themselves from other nurses. I postulated this was the result of a choice nurses had and made.

So, I remember once I—I ended up—it was actually in New Mexico, it was in the Indian hospital and I—I got this patient that was dying from liver, uh, failure. And she had kind of copious amounts of diarrhea, and she had had diarrhea for kind of days and days, and she was dying. And I remember coming on, and the nurses were all complaining about kind of like by the time you get her cleaned up, you’d roll her over, and she’d just fill the bed again. And it’s kind of aggravation like that, and I remember going in and her telling ‘I’m so sorry. I’m so sorry.’ And I remember making a decision that I would treat her with total tenderness and that I would keep her as clean as possible, but also not keep her clean in the clinical way, but be really gentle with her and reassure her that I was OK. . . .

So, I think that I—that kind of preserving some of the dignity or caring for them in a way that my touch is gentle and kind. I think—I think that’s what I’m more aware of is—is than I am of, I didn’t, I wasn’t, I guess I’m—this was—it is very personal to clean someone up so in a sense I was invading her body space, but I wanted to do it in a way that was not humiliating for her. Does that make sense? —Participant 10

And: Interviewer: When you say you always have been caring, what does that mean to you?

Interviewee: That means to me I acknowledge the patient. From the time that patient gets in there, I introduce myself. I introduce my staff even before the doctor gets in the room: Doctor so and so is our doctor. This is our tech, our medic. I’m your nurse. I’m going to be making sure you’re medicated. You know, do you need a blanket? You know, just making them feel comfortable instead of just lie on the table, put your feet up, lie back, and that’s, I don’t think that’s the practice. —Participant 13

Participant 8 was particularly uncompromising in her choices and contrasted her conduct to that of other nurses:

You know, it's like, I'm gonna start looking for a new job. You know, that's, I do, I get very upset, if I feel it's wrong. You know, or if people do it with cruelty, and coldness, I get really upset, right? And you'd see that. That would happen a lot. When you're doing something horrible, that's done with the best intent, and with kindness, and with actually, reasonably, will, will be the best for the person, I think it's OK. You know, in my own system. I wouldn't have been able to stay in nursing, I guess, if I felt differently. —Participant 8

And: Bunch of nurses who are really quite cold and cruel most of the time, right? Not always, yeah, yeah, there was a lot of that nasty, cold, you know, ugh, feeling in there. . . . Where you'd have, um, a bitchy, nasty group of nurses, and they set that environment for the entire unit. —Participant 8

Participant 10 described the “mechanical way” in carrying out procedures, in which the patient was treated as an object or a task to be completed.

Do it . . . in a more mechanical way, which some nurses seem to do these things in kind of a mechanical way. . . . You know, it was kind of a task, and they were focused on the task and not on the person. . . . One of the ICUs I used to work in every, you know on all of the even hours, it was time to—the good thing was, we would all do it together. We would go down the line, and everybody would get turned, but there were nurses that would just kind of grab that under sheet, the draw sheet and just zing the patient, you know, and I don't do that. I'm actually very slow, and I'll use the draw sheet and sometimes if I think it's better, I'll use the whole sheet to cradle the person as they come up more. Do you know what I mean? —Participant 10

The act of setting oneself apart appeared to be a choice nurses had and made.

Underlying this choice was the notion of an acceptable and unacceptable conduct of nurses.

Nurses not only distinguished their conduct from the conduct of other nurses but some nurses also appeared to perceive themselves as a deviation. What was gained by conducting oneself differently? It was conceivable that setting oneself apart was a way of preserving a positive self-image and resolving the contradiction that those who were supposed to provide comfort also inflicted pain. It was also conceivable that setting oneself apart might not be a matter of choice but rather an expression of who these nurses were.

Becoming the mean nurse (Nurse Ratched). Nurses knew that carrying out procedures affected patients. According to Participant 5, this rose to the level where patients “hate me for making them do it.” Participant 7 noted that he became the target of a patient’s reaction.

I don’t like inflicting pain on my patients, but I understand that by doing the procedure, they’re better off. Especially with the surgical patients. They need to get up, and they need to move; otherwise, they develop more complications. The healing process is just faster when they get out of bed and move. Even though they may hate me for making them do it, eventually the outcome is better. I explain that to them, and they understand that. Of course, it’s not fun to be in pain, either. —Participant 5

And: I’m gonna kind of block that, even though you’re yelling and screaming and swearing at me, I’m going to block that ’cuz I know what I’m going to do to you; it might just save you. —Participant 7

The fictional character of Nurse Ratched in the movie *One Flew Over the Cuckoo’s Nest* has become a stereotype (epitome of a villain) as evidenced by Participant 11.

I never want to be considered, like, who’s that nurse, Nurse Hatchet. Isn’t that the nurse? There was a movie, and I watched it. And the nurse was just this really mean lady, and I just thought, ‘Ooh, I don’t want to be that person.’ —Participant 11

It appeared to me that the character of Nurse Ratched touched on something that is sensitive. I watched the movie. My perception of her conduct is quite different compared to her image: I see her as a caring psychiatric nurse who carried out her duties faithfully with high professional integrity and imposed rules on a person who showed traits of an antisocial character. She repeatedly went out of her way to assist patient Randle Patrick “Mac” McMurphy. Nurse Ratched related to the patient as a psychiatric nurse should, according to the accepted treatment course, which was negotiated in treatment team meetings. Yet, Nurse Ratched has become the stereotype of the mean nurse, as evidence by the quotation by Participant 11. Why does this matter? It was conceivable that Nurse Ratched symbolized

what nurses perceived as a possibility (becoming mean). Nurses knew they change over time, but it appeared that the change largely went undetected, and as such, changing into a negative epitome was a possibility.

Nurses Were Influenced by Their Environment

Nursing units appeared to create “environmental” factors [Participant 8]. These environmental factors also could be viewed within the context of the prevalent nursing discourse on a particular unit that affected and possibly changed individual nurses.

So, if you bring nurses into that, they are taught to be like those nurses, in how they treat people. And if they're brought into CCU (like in the good old days, right?) where we worked well together, and they, and we really showed a great deal of care and sensitivity for our patients, right? And, then they're taught that. So, you know, it's like, it's like, it's like so specific to each environment. —Participant 8

And: Other people, you put in that environment, and they'll become like those nurses, right? Because they aren't that strong in themselves, you know. So, um, and I think there's some ICUs that are probably more like what we had in CCU. So, but, but, I mean, there's just a thousand different factors, right? I remember, I mean, and we all know that there are many nursing units, even not just ICU, where you'd have, um, a bitchy, nasty group of nurses, and they set that environment for the entire unit, in how everybody's treated, and how the patients are treated, and how everything's done. You know, and then people get infected by that, you know, when they work there. —Participant 8

Equally important was something within each nurse that s/he brought to the bedside.

You know, some people are never gonna get mean. You know, like, how you don't know, we have a nurse's aide who just became a nurse. Juanita is always going to be good and kind, because she's that type of person, and put her in hell, and she's not gonna change. You know, she's just that way. So, you could put her in ICU, and she's still gonna be kind to the people, because she, there's something in her that can't be changed that way. It's so deeply who she is. —Participant 8

Nurse managers. I interviewed several nurse managers (Participants 4, 12, and 14; Participant 14 identified as a nurse administrator). I interviewed the first nurse manager twice after realizing that I needed to adjust my line of questioning in an attempt to elicit responses

from an administrative perspective. Participant 14 indicated that CIP was not pertinent to her area of practice environment (assisted living), and soon after the start of the interview dismissed any further questions. When questioned with regard to CIP, Participant 12 addressed the question within the broader context of pain management (which I viewed as separate from CIP: a physical encounter in which typically one nurse carries out a nursing procedure that may cause discomfort to the patient).

As a manager and in leadership in an acute care setting, I preach the same thing to my staff, and I tell them that our goal is to make sure the patient understands what's happening, and we give them as much information as we can about what we're going to do and what might happen. And we also try to prepare them physically or mentally in the best-case scenario, and if they ask for medication, or they request this or that, then we try to accommodate them. —Participant 12

The nurse manager spoke about her approach to nurses with regard to pain management.

I've had resistance, and I've had to talk to the nurses. And I sit down and talk to the nurse, and I explain to them the reason why we're a nurse and why we do things this way and that we're out here to take care of these patients. That's our job, to make them get better, healthier, whatever it is so they can go home. So however we need to do that, we need to adjust to make sure that the patients have the best outcome or experience in the hospital. Now it comes from an administrative point of view. — Participant 12

Participant 12 identified deficits in pain management on her unit (possessive pronoun used by nurse manager) and educated her staff with regard to pain and pain management; subsequently, underprescribing analgesic medications became an issue. Two things appeared noteworthy. First, CIP was recognized within the context of pain management. It was not clear whether CIP was sufficiently different from other pain management issues to warrant a different approach. Second, this nurse manager was able to affect the behavior of nurses with regard to pain management. CIP has been addressed by Czarnecki et al. (2011) in the form of clinical practice recommendations. Given the impact the nurse manager had on pain

management, it was likely that CIP could be addressed via policies and procedures (P&Ps); but it appeared equally important that nurse managers held nurses accountable.

Nursing instructors. Nursing education played a pivotal role in laying the foundation for the conduct of nurses and in shaping the nursing discourse. Participant 2 commented on how nursing school left her unprepared to face the emotional conflicts inherent in day-to-day nursing practice.

The one thing when I was teaching, which struck me as odd, I mean, they were preparing to, these nursing students, to be very good technicians. But we didn't talk about how to deal with the moaning, the pain. We didn't talk about it. And, uh, um, and I, I mean, I worked in hospitals my entire career. So I always had peers. Um, and on a particularly bad day, when you really feel bad about what you did, or what happened, actually what happened, then kind of talking it out with peers. But it, it kind of strikes me as odd that in nursing school, this is not addressed, period. I mean, I mean, here we're breaking something very basic, and we don't tell them what that might do to them, or how to deal with that. Or when people get really angry, people start yelling, or people even lash out. Um, I mean, when you take the time to really take in their response, and not completely turn off, you see their point. It's like, what is it that we're telling each other? —Participant 2

The interviews of the two recently graduated nurses (Participants 3 and 11) were noticeable for the absence of any mental framework with regard to CIP; both then-student nurses referred to their instructors to assist them in gauging a clinical situation. While Participant 3 appeared to have no issue in accepting the explanation, Participant 11 struggled.

It was effective [referring to a rectal disimpaction], but it rang out in my head not because it was a painful experience for the patient, but it was something where the nursing instructor had, you know, supervised me over it, at the time there was some question or not with the other nursing instructor if it should have been done. — Participant 3

And: In my mind, I was thinking about what was the way that, you know how can I do this so that he wouldn't be experiencing as much discomfort or as little discomfort as possible. Like if there was any way that she [referring to nursing instructor] could instruct me so that [inaudible] at the time. —Participant 3

And: I had another instructor who, she kind of just told me, ‘You always have to weigh the benefits and costs. If the benefit to your patient may inflict a little bit of pain, but it keeps them safe, and it keeps them well, is it worth the cost, that if you didn’t do it, what might be the end result?’ So, she said, ‘You always have to look at the benefits and the cost.’ She said, ‘It happens in treatment all the time.’ —Participant 11

I concluded this section by quoting Participant 4 who was also a part-time nurse educator.

Same with nursing students, and I think if you, you know, help them get out of their own, ‘I’m gonna hurt this person.’ And help them expand that experience to, ‘OK, well that may be true. It may not be true. But what’s the purpose behind us doing this? This procedure?’ And help them explore that, and see the greater good, and help them, because when people do, ‘I don’t wanna do it because I’m gonna hurt them,’ they’ve got a very narrow focus. —Participant 4

Your job as an instructor is to broaden that, and to help them understand, in a larger picture, ‘Yeah, that shot hurts, but do you want your kid to get polio? Do you want your kid to get, you know, whooping cough?’ And you know, fill in the blank, whatever it’s for. If you can help the student broaden their perspective on what they’re, the task that they’re doing, that makes a big difference, I would think, to any thinking individual. And that’s our job as instructors, to do that, I think. —Participant 4

Summary and Conclusions

These findings showed the complexity of CIP and the complexity of the experiences of nurses within the context of CIP. I noted earlier that I could have pursued a number of paths during the data analysis, but I kept returning to the questions: How did nurses explain CIP? How did nurses make it “OK?” I believe that I developed a model that is worth exploring and expanding. I have wrestled with the data over the past few months and found myself amazed at the findings. I have learned from the participating nurses and learned about CIP.

Given that so little was known about CIP, I wanted to start this summary with a brief overview of pertinent findings. Typically, at least one nurse and a patient co-created the clinical situation in which CIP occurred. However, other nurses, providers and/or family

members need to be considered as participants. CIP took place in relative secrecy. The significance of this setting was unknown. Procedures were initiated by provider orders, nurses following accepted standards of care, or by requests from providers, patients and family members. Painful procedures spanned a wide variety of procedures, and procedures themselves were poor predictors of potential discomfort. Nurses could not feel the pain they inflicted. The descriptor of unintended pain proved to be flawed because nurses did not intend to harm patients when carrying out procedures. CIP was an anticipated occurrence. CIP was unavoidable and treatable. CIP was different from other pain by its injurious nature. Patients experienced emotional pain and fear in addition to the physical pain.

At least one nurse and a patient were physically present in clinical situations when a procedure was carried out and as such could be described as a social interaction; social interaction did not mean that nurse and patient were equal partners. Relating to patients was not explored within the context of this study. This amounted to a major limitation because CIP was an interactive process in which patients and nurses influenced one another; CIP was a co-created experience. Nurses reported obtaining consent and preparing the patient. At times, nurses requested active participation from patients. Nurses interacted with patients in a variety of ways. Nurses' opinions about patients affected how nurses viewed CIP and, more importantly, revealed the constructed nature of nurses' estimation of CIP's painfulness and CIP itself. Nurses were accountable to a number of constituents and chose their affiliation, which, in turn, affected nurses' reported conduct and how nurses defined outcomes of procedures. Within the context of children and projected medical futility, nurses placed CIP within the context of torture. Nurses took charge in many clinical situations and proceeded against expressed refusals or physical resistance if deemed necessary or if indicated. Nurses

had and exercised power over patients. One nurse placed CIP within the context of transgression into personal space.

Nurses were motivated by obedience and a sense of service to the extent of duty. A few clinical situations revealed potential organizational factors that could have contributed to CIP (e.g., lack of back-up staff). Procedural difficulties shed light on the complexities involved in carrying out procedures and revealed the potential for suboptimal care in which abuse was conceivable. Nurses demonstrated resourcefulness in finding solutions.

Intent and intention did not appear to be an important consideration for most of the participating nurses. Nurses identified a number of mitigating and aggravating factors with regard to CIP. CIP was recognized as important but, given the broader picture, was considered to be of a lesser priority. All nurses expressed not liking to inflict pain. For some nurses inflicting pain was sufficiently problematic that they left certain work environments or even considered leaving the nursing profession.

It was interesting to note that one particular clinical situation was viewed as exciting by some nurses and disturbing to another nurse. Nurses had a choice in where to put their attention: task versus patient. Nurses held certain views about carrying out procedures and inflicting pain which was captured as attitude. It appeared that nurses did not view CIP as a moral issue.

Nurses could not feel the pain they inflicted, and they confidently estimated the degree of painfulness. I demonstrated the constructed nature of the estimation of the painfulness of CIP. Nurses were faced with a gap: not knowing pain, yet having to respond to it. Nurses transformed CIP by unmaking the patient's experience and the remaking of CIP.

Nurses used CIP as a clinical tool. Nurses were concerned with making CIP right and did so by a review and decision-making process that culminated in passing judgment.

The last section of the chapter captured responses by nurses on a physical, emotional, and cognitive level. It became clear early on that some nurses were conflicted while others were not. I explored the conflicted nurses within the context of attitude. It appeared as though the conflicted nurses allowed themselves to be affected by the patient's experience, and although these nurses experienced emotional pain as a result, these nurses also appeared to have a deeper sense of purpose and appeared to have derived greater satisfaction. Nurses also disengaged emotionally, described as compartmentalizing or shutting off emotional things. Empathy was an unanticipated finding. Empathy was noted as well among the nurses who were neutral (i.e., not conflicted) with regard to CIP. Nurses used empathy as a verb, an adjective, and a quality - something that could be lost and possibly learned. Empathy appeared to be a form of engagement and appeared to have transformative potential. Chapter 4 concluded with brief sections on nurses' responses, how nurses changed over time, the effects of environments (specific nursing units), nurse managers, and nursing education.

What did I conclude from Chapter 4? CIP was a rather complex phenomenon. Nurses' experience of CIP was distinctly different from the patient's experience in a number of ways. CIP was unavoidable for nurses. And although CIP was unavoidable, CIP was treatable. Nurses knew that procedures hurt and were aware of the potentially injurious nature of CIP. It became clear from the onset that nurses did not like to inflict pain. Nurses were affected by CIP and some were conflicted. Nurses were actively involved in all aspects of CIP, and they made choices. How nurses made choices was influenced by the chosen affiliation among a number of very different constituents. Nurses responded to CIP by

asserting authority, taking charge, making CIP right, and filling the gap. I demonstrated the constructed nature of the nurses' estimation of CIP's painfulness and the constructed CIP itself. Nurses transformed CIP through unmaking the patient's experience and remaking CIP. The unmaking of the patient's experience was a process, and the remaking of CIP was a *product* (i.e., an interpretation). I viewed CIP as a process, not as an entity or a hindrance to overcome.

There appeared to be nearly an even split among nurses who were neutral toward CIP versus the nurses who struggled with having to inflict pain. Being a novice nurse did not explain this finding, although nurses did change over time and were influenced by unit environments; nurse managers appeared to have an impact on nurses' conduct. I explained the conflicted nurses within the framework of attitude and proposed that the conflicted nurses viewed inflicting pain as inherently "wrong" and that any justified rationale did not alleviate the discomfort these nurses experienced. Attitude is not synonymous with empathy; some nurses who were neutral toward CIP appeared equally empathic. It was perceivable that empathy was a positive and possibly needed contribution. It was conceivable that the conflicted nurses could be viewed as representative of nursing conscience.

The role and use of empathy and sympathy was a somewhat unexpected finding. Empathy and sympathy were used as adjectives, nouns, and, on one occasion, as verbs. Empathy and sympathy served a purpose for the nurses who utilized this feeling, connection, approach, or attitude. Yet, being empathic also meant that nurses felt pain themselves and turning off emotionally appeared to be a "logical" response. I wondered whether empathy and sympathy were as much the problem as they were the solution. It appeared that empathy

and sympathy had a transformative quality that transformed a potentially “bad” pain into an act of healing.

Since starting to explore the phenomenon of CIP in 2004, I have been greatly influenced by Wilson-Thomas’ (1995) statement, “Nurses practice in a profession where its philosophy contradicts its action” (p. 571). I no longer think of CIP as a contradiction, per se. CIP and the various reported conduct of nurses indicated the full spectrum of response patterns. CIP was something nurses used, constructed, and controlled. I have identified processes that clearly differentiated CIP from being just a pain management issue. I concluded that CIP was sufficiently different to make it its own entity.

Chapter 5 Discussion

Based on 13 in-depth interviews, and the use of grounded theory I discovered the theory of *togetherness*: the bringing together of the professional nurse (defined by education, training, and skill and henceforth referred to as the professional nurse) and the nurse person (broadly defined as a human being who is also a professional nurse). It is important to note that the differentiation between professional nurse and nurse person is theoretical in nature; the professional nurse and nurse person are united in the nurse. As such, when I subsequently refer to nurses I intend to describe the blend of the professional nurse with the nurse person. I argue that it is the nurse person who distinguishes the professional nurse.

The theory of togetherness by itself does not explain the noted variations in the data. I viewed variations in nurses' reported conduct on a continuum and postulated that it was the nurse person who positioned the professional nurse on this continuum, a process that I call *positioning*.

In addition to the theory of togetherness and the process of positioning, major findings of the study were: (a) the experiences of nurses were unique and distinctly separate from the patients' experiences; (b) the professional nurse constructed, used, and controlled CIP; and (c) the processes of unmaking the patients' experience and the remaking of CIP explained the under or nonrecognition of CIP.

Initially three research questions guided the interviews: What were the experiences of nurses with regard to CIP? How did nurses explain CIP? And lastly, how did nurses, if indicated, reconcile (and/or justify) CIP? The diversity and complexity of the nurses' experiences quickly revealed the limited and biased nature of these questions; as I continued to interview nurses, it became clear that different questions needed to be asked in order to

obtain a deeper understanding. In hindsight, the initial research questions appear naïve. I believe that the study answered the original three research questions and that the findings of this study also went beyond these questions.

Research Question 1—What were the experiences of nurses with regard to CIP?—was largely answered in Chapter 4. I identified the processes of asserting authority, taking charge, making CIP right, filling the gap, particularly the unmaking of the patients' experience and the remaking of CIP. In chapter 5 I revisited the various experiences of nurses only as these experiences proved to be significant for theory of togetherness and positioning. Research Question 2—How did nurses explain CIP?—was answered primarily by the finding that the professional nurse constructed, used, and controlled CIP. More specifically, I identified the processes of unmaking of the patients' experience and remaking CIP. Research Question 3—How did nurses, if indicated, reconcile (and/or justify) CIP?—proved to be too narrow in focus and needed to be expanded. Nurses used a number of processes, particularly justifying and passing judgment, to not only alleviate their discomfort but also to enable them to carry out painful procedures.

I utilized Glaser's GT methods to code, analyze, and organize the data obtained from the interviews. Chapter 4 contained the descriptive findings that form the basis for the theory of togetherness and the process of positioning. In writing Chapter 5, not only did I notice a number of gaps in my findings, but I also had new insights and established links between nurses' perceptions, reactions, interpretations, and conceptualization of their experiences. This was discussed in a debriefing with my committee chair and consultant, and I amended my findings. In particular, the conflicted nurses presented a theoretical challenge that forced me to return to the data; the theoretical coding of the data from the conflicted nurses sparked

the theory of togetherness. Therefore, I will present findings related to the conflicted nurses before launching into the theory of togetherness. I will conclude this section by addressing the question of whether CIP was a moral or ethical question and whether CIP was a pain management issue. Chapter 5 closes with a discussion of methodological considerations and limitations, implications of this study for nursing, and future research.

Conflicted Nurses: “Losing Sight of Myself”

The conflicted nurses created a theoretical challenge: First, how could I explain why CIP was problematic for a particular nurse in one instance but not in a different instance? Second, why was CIP problematic to some nurses but not all? And what exactly was problematic for the nurses who were conflicted? I specifically re-read the interviews to obtain a more complete picture. CIP was a likely and anticipated occurrence associated with common nursing procedures carried out on a daily basis. All of the participating nurses, including the conflicted nurses, justified having to inflict pain and passed judgment on how to proceed. The infliction of pain in and by itself was largely unquestioned, with the exception of Participant 11 (a recent graduate) and to a degree by Participant 2 (a nurse with many years of experience). I have used the same quotation by Participant 11 previously but repeat it to illustrate my point:

But, at the same time, I just remember looking at her, and she kept fighting, and I thought, ‘Well, this person who I had thought was a vegetable, was not that much of a vegetable, because she could feel pain.’ I remember, I just, I cried, because it was so, for me, it was disheartening. I kind of felt like I was being cruel . . .—Participant 11

In this comment, witnessing the effects of carrying out a painful procedure was problematic for Participant 11. In Chapter 4 I conjectured that the conflict might be explained within the context of attitude and that for some nurses inflicting pain was simply

unacceptable. Another possible explanation could be that witnessing the effects of one's actions challenged Participant 11's self-image as a person or her self-image as a nurse. In returning to the data, I noticed that the conflicted nurses appeared to report empathic responses more frequently and that the emotional state of patients under their care appeared to be of greater significance. But not all nurses who were empathetic were conflicted. Participant 10's words stood out: "Losing sight of myself," raising questions about personal boundaries or whether these nurses had an "awareness" (skill set?) that set them apart from other nurses.

Interviewee: And their kind of anguish that I am the cause of, but I am much more focused on their experience of it rather than my experience of me. Does that make sense?

Interviewer: Yeah, it does.

Interviewee: I have a tremendous capacity for kind of experiencing losing sight of myself and being acutely aware of what the other person is experiencing. —
Participant10

I returned to the data to obtain a more complete picture and deeper understanding of what these words could mean. Participants 2, 7, 8, 10, 11, and 14 expressed emotions in the context of CIP. The following clinical situations were problematic for nurses:

- there appeared to be triggers, such as moaning, crying, or screaming;
- there was conflict when a procedure was called into question;
- the emotional state of a patient, particularly despair and depression, clearly affected the conflicted nurses;
- when nurses projected medical futility and were asked to carry out a procedure that they believed was no longer indicated;
- when providing nursing care to children;

- when the nurse perceived a shift in her/himself of unacceptable conduct (“I would get mean myself,” Participant 8); and
- the conduct of other nurses, described by verbiage such as cruelty and coldness, and the perceived abandonment of patients.

In contemplating these findings and attempting to explain conflicted nurses, I considered whether the conflicted nurses faced moral or ethical dilemmas but could not find the supporting evidence in the data. I considered duration of work experience, but that was unsupported by the demographic data. There appeared to be a link with work environments (specific units), as nurses reported leaving certain units, but work environment did not explain the overall pattern. For lack of a better explanation, I succumbed to calling it “personal.” This brought to light an important and unaccounted for assumption: I had viewed nurses as *professionals*, which I understood to mean that nurses were exemplars and although not void of personal or emotional responses were unaffected by them. The data indicate that nurses are people with human responses, and I realized that I had made an assumption about nurses. My now recognized assumption was inconsistent with the data in which large variations were noted. I then realized I had no concept of a nurse as a *person*. I realized I needed a theoretical framework to define who or what a nurse is.

Who or What Is a Nurse?

I readily identified multiple definitions of nursing, such as from the American Nursing Association: “Nursing is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations” (American Nurses Association, 2015, para. 1) or the National Council of

State Boards of Nursing (NCSBN): “The practice of nursing requires specialized knowledge, skill, and independent decision making” (NCSBN, 2015, para. 1). From these definitions, I learned about the general scope of nurses’ work and that specialized knowledge and skills prepare nurses to carry out their duties. In order to answer my question, who or what is a nurse, I went to the University of Hawaii’s University Hamilton Library and reviewed a number of readily available publications by nursing theorists. In the preface to her book *Notes on Nursing: What it is and What it is not*, Florence Nightingale (1859/1992) wrote, “Every woman, or at least almost every woman in England has, at one time or another of her life, charge of the personal health of somebody, whether child or invalid—in other words, every woman is a nurse” (Preface, para.1). Ernestine Wiedenbach (1964) defined a nurse as a functioning human being who acts, thinks, and feels, which not only affects what s/he does but how s/he does it. Wiedenbach acknowledged the unique nature of each nurse. Virginia Henderson (2006) noted that there is no universal definition of what constitutes a nurse and cited herself to present her understanding of a nurse. “The nurse is temporarily the consciousness of the unconscious, the love of life of the suicidal, the leg of the amputee, the eyes of the newly blind, a means of locomotion for the newborn, knowledge and confidence for the young mother, a voice for those too weak to speak, and so on. . . . This concept of the nurse’s unique function demands that nurses understand the fundamental needs of man so that they can help their clients or patients provide for all those needs, even during illness” (p. 26). Henderson noted that these nurses were “produce[d]” (p. 27). Dorothea E. Orem (1980) noted, “The title nurse and the title nurse’s patient signify the social positions and roles of persons who come together with the related general purposes of providing nursing and being provided with nursing. The capability to provide nursing to others includes specialized

abilities necessary for the technological operations of nursing practice and for following social and interpersonal operations necessary for nursing practice” (p. 103). Sister Calista Roy and Andrew (1991) noted, “It is the nurse’s role to promote adaptation in situations of health and illness; to enhance the interaction of the person with their environment, thereby promoting health” (p. 20). Betty Neuman and Jacqueline Fawcett (2002) defined nursing as “a unique profession concerned with all variables affecting clients in their environment. Nursing is preventative intervention (p. 323). Jean Watson (2008) noted that without the 10 carative factors, “nurses may not have practicing professional nursing but instead were functioning as technicians or skilled workers within the dominant framework of medical technology” (p. 3).

It appeared that these theorists agreed on the special skills and knowledge of nurses, and they defined a nurse based on her/his relationship to the patient. Many of the cited theorists developed sophisticated definitions of what constitutes a person, but these definitions referred to patients—few included the nurse her/himself. I postulated that there is a difference between who a nurse is and what s/he does (essence versus professional activity). Given this proposition, I needed to find a definition that would be inclusive. I searched for a definition or view that would be representative of all of the nurses who participated in this study. Given that I intentionally did not adopt a particular theoretical viewpoint, I needed some form of a definition. I looked up the definition of a nurse in the Merriam Webster Dictionary (2015), which defined a nurse as “A person who is trained to care for sick or injured people and who usually works in a hospital or doctor’s office.” I then looked up the word “professional” in the same source. Professional was defined as, “Someone who does a job that requires special training, education, or skill.” Both definitions

referred to training and skill; neither assigned any type of personal attributes to nurses or to professionals. Given that the nursing theorists, cited above, appeared to agree on specialized skills and knowledge, I defined a professional nurse solely based on skills and knowledge pertinent to nursing—void of any attributes of a person. The lack of personal attributes was supported also by the fact that the professional nurse was externally determined, requiring catalysts and triggers in order to carry out a procedure. I postulated that it is the self-determined nurse person who distinguishes the nurse. Jean Watson (2008) noted that without the 10 carative factors nurses were mere technicians. Watson acknowledged a dichotomy (nurse versus technician). This dichotomy validated my hypothesis that something else (beyond skills and knowledge) is needed to distinguish a nurse.

Many of the participating nurses made references to whom they were (as people), setting themselves apart and making decisions based on how they (personally) viewed CIP. In addition to being a professional nurse, nurses are people. This perspective led to the conception of the nurse person. The nurse person is self-determined, and, among many other attributes and qualities, the nurse-person has ethics, morals, emotional responses, and an ability to connect with patients and other people. The nurse person positions the professional nurse (see subsequent section on positioning). The distinction between the professional nurse and the nurse person permitted me to explain variations in the data.

The adjective “personal” has been utilized in nursing (e.g., personal knowing, views and perspective, experience, beliefs, satisfaction, control, characteristics, tendencies, agenda, etc.). I viewed the nurse person not as an attribute but as an entity: without the nurse person, a professional nurse is reduced to mere skills and knowledge. I did not attempt to define

nursing, which I viewed as a different question. I asked: How could nurses define what they do without first defining who they are?

What has been presented so far was found in the data and needs to be differentiated from what nurses could be or should strive to be. The professional nurse and the nurse person are united in the same physical body; as such, the distinction is primarily theoretical. I believe that this distinction could have important implications for nursing practice and particularly for nursing education.

In returning to the conflicted nurses and in an attempt to explain their significance, I propose emotions were the meeting point between the professional nurse and the nurse person. One could argue that a nurse can be both professional and a person with emotions and that it is in how s/he manages the emotional responses alongside the professional ones that matters—to which I respond foremost: Who is doing the managing? What constitutes a professional? More importantly, this proposition appears to affirm the proposed dichotomy and tension between the professional nurse and the nurse person. Before commenting further, I would like to quote two participants (both quotations were used previously).

I remember, I just, I cried, because it was so, for me, it was disheartening. I kind of felt like I was being cruel, and I remember my instructor came in, and she's like, 'You need to toughen up.' And I was just like, 'I don't want to toughen up.' —
Participant 11

You know, I learned pretty quickly that I broke all of those rules. I mean, you know, I hugged families and I cried with them, you know, and I cried with patients and sat with them. You know, and I realized that that I couldn't agree with those rules of nursing that you were supposed to somehow come in in your perfect white starched outfit and be this kind of tower of strength, which meant you were nonemotional. —
Participant 10

I question the argument about effective management of emotions: First, the quotations above clearly showed the existence of a nursing discourse; in both quotations,

nursing discourse is advocated for by an entity with authority and power. Second, there is a notion that certain conduct or certain responses are acceptable or unacceptable. What is acceptable or unacceptable is subject to change. Nursing discourse is constantly evolving, and what is considered “right” might be viewed differently at another point in time. Third, who is to say what was right? The proposed distinction between a professional nurse and a nurse person is void of any imposition of what a nurse should be. This distinction leaves room to define who or what each nurse is or wants to be through the process of bringing together the professional nurse and the nurse person, a process that I labeled *togethering*. The proposed distinction between the professional nurse and the nurse person was derived from the data and as such can be viewed as what is as opposed what ought to be.

Togethering: A Grounded Theory Related to Clinically Inflicted Pain

All clinical situations were unique; no two nurses encountered the same clinical situation. Given the GT methodology and methods, I focused on processes. The challenge was to develop a theory that not only was sufficiently broad to capture all the variation but also succinct enough to capture the experience of (all) nurses: the theory of *togethering* achieved these goals. This theoretical model explained the large variations found among the participating nurses, the conflicted nurses, and the subjective and constructed nature of some of the processes utilized by nurses in the context of CIP. In addition, this theoretical model also explained why some well-meaning nurses (and all participating nurses meant well) could be perceived as cold as they could lack the personal attributes brought forth by the nurse person. *Togethering* was the process of bringing together the professional nurse and the nurse person. The degree of *togethering* was determined by each nurse person. The nurse person positioned the professional nurse in a variety of processes, as shown in Tables 5 through 14.

Within the context of CIP, togethering determined where nurses placed their emphasis.

Table 4 presents basic assumptions of the theory of togethering.

Table 4

Basic Assumptions of the Theory of Togethering and Positioning

Basic assumptions	Found in the data
Nursing has a reality that is independent from patients.	Best demonstrated by the process of filling the gap (unmaking of the patient's experience and remaking of CIP).
A professional nurse is defined only in terms of skills and knowledge.	No, but other explanations were not there either.
A professional nurse is externally determined.	I identified triggers and catalysts.
There is a nurse person that humanizes the professional nurse; the nurse person is self-determined.	<ul style="list-style-type: none"> • Conflicted nurses • Use of personal pronouns Nurses <ul style="list-style-type: none"> • Constructed meaning • Made decisions on what they thought was right •
Togethering is the coming together of the (professional) nurse and the nurse person.	The proposition of the nurse person explained the: <ul style="list-style-type: none"> • variations • subjectivity • randomness, uniqueness •
All relating can be explained only to the degree the nurse person relates the clinical situation to herself or himself.	Explained by the reflective nature of the empathetic nurses.
All nurses mean well.	Given that the study was based only on interviews, results were based on what nurses shared.
All nurse persons are unique.	Explains variations.

CIP was a relatively unexplored phenomenon within nursing, and I believe my research revealed the complexities associated with CIP. I believe the theory of togetherness explains the reports of the participating nurses and allows for a degree of prediction. I propose that togetherness adds to the discussion of what constituted a nurse and thus adds to nursing theory. I argue that this theory has practical applications, particularly for nursing education, by emphasizing the significance and the necessity of the nurse person for the professional nurse.

I came up with the word togetherness myself; I completed a Google search and found that togetherness was described as a new buzzword and has been used with a variety of meanings for coming together or bringing together different parties. Within GT methodology the use of a gerund has been a tacit rule in naming basic social processes (BSP). Glaser (1978) explained, “BSP are abstract of any specific unit’s structure and can vary sufficiently ... independent of structural units, that is, free of their time and place and the perspective of their participants” (p. 100-101). As such togetherness was deemed a fitting title.

Positioning

What became abundantly clear with regard to CIP was that there were many variations in the processes utilized by nurses. I arrived at positioning when I explored what all nurses did and how nurses were different. All nurses engaged in the various processes, but their reported conduct varied considerably. At times, nurses were being positioned (e.g., by nursing instructors, nurse managers, or peers [unit environments]). Positioning has the following characteristics: It is subjective, fluid and changeable (being fluid also can mean being static), active or passive: chosen or imposed, and characteristic for an individual nurse. Of these characteristics, fluidity appeared especially important. If positioning became static

(or was imposed) when there was a lack of (perceived) options, clinical situations became problematic, and nurses responded by feeling powerless. In order to choose, a nurse needed to realize that s/he had choices—without this realization, a nurse did not have choices.

For ease of reading, I compiled a number of tables listing many of the processes utilized by nurses. Each listed process is divided into three columns: the left column and the right column contain possible endpoints as identified in the data; the middle column provides either pertinent aspects related to the processes or a range of possible positions. These tables (Tables 5-14) are not intended to be comprehensive, nor do they contain all of the processes utilized by nurses.

Table 5

Positioning of Nurses When Relating to Patients

Relating to Patients		
Disengaging (focused on procedure)	Various degrees of: <ul style="list-style-type: none"> • Explaining procedures • Providing a rationale • Negotiating how procedures are carried out • Giving patients choices • Seeking consent (which included patients being given the choice to decline a procedure) • Acknowledging the experience of pain and negotiating how to alleviate the discomfort • Adjusting the proceeding of a procedure according to patients' responses • Acceptance of patients' responses and responding to them • Degree of awareness with regard to prejudice and acceptance of selected versus all patients 	<ul style="list-style-type: none"> • Engaging • Empathetic

Table 6

Positioning of Nurses When Viewing Patients

Viewing Patients		
An object of a nursing intervention or task to be completed	<ul style="list-style-type: none"> • “Vegetable” • Self-awareness • Prejudice <p>Of note: Children’s and cognitively impaired adults’ responses disabled the unmaking of the patient’s experience</p>	All patients are persons

Table 7

Positioning of Nurses with Regard to Affiliation and Accountability

Affiliation and Accountability		
<ul style="list-style-type: none"> • Medical provider(s) • Supervisor(s) • Policies and procedures • Peers; unit environment 	<ul style="list-style-type: none"> • Nurses adjusted carrying out a procedure depending on who they affiliated with • Affiliation with patients was created • Recognizing patients’ responses and responding to them • Accountability for patients’ experience 	The ultimate authority is the patient

Table 8

Positioning of Nurses When Viewing Procedures

Viewing Procedures		
<ul style="list-style-type: none"> • Medical indication and/or provider order were most important • The end justified the means • Completion of procedure mattered most; patient became an object • Skills, demonstrating competence • Carrying out a procedure was exciting, a challenge, rewarding 	<ul style="list-style-type: none"> • Medical and/or nursing indication for a procedure • Broader context of the patient as a person: Is this right for this patient? • Projected outcomes, particularly projected medical futility 	<ul style="list-style-type: none"> • It is justified only if permitted by patient • Torturing patients • Carrying out procedures is a necessary evil

Table 9

Positioning of Nurses with Regard to Motivation

Nurses Were Motivated by		
Obedience (following orders)	Reported conduct that appeared to be related to or affect motivation <ul style="list-style-type: none"> • Engaging with ordering provider, such as seeking clarification, providing additional information, etc. • Seeking involvement of patients • Degree of personal accountability 	Service and/or duty

Table 10

Positioning of Nurses When Carrying out Procedures and Taking Charge

Carrying out Procedures: Taking Charge		
Ready to exercise power if deemed necessary (low threshold)	Various degrees of engagement with patients	<ul style="list-style-type: none"> • Not exercising power • Aborting procedure if consent is withdrawn • Viewing CIP within the context of abuse

Table 11

Positioning of Nurses in the Process of Making CIP Right

Making it Right		
Procedure was not questioned	<ul style="list-style-type: none"> • It was right when various conditions as defined by the nurse were met • Making it right by interacting with ordering provider (voicing questions or concerns, providing additional information) 	Procedures were justified solely on the basis of patients' needs and desires

Table 12

Positioning of Nurses in the Unmaking of the Patient's Experience

Viewing Clinically Inflicted Pain: The Unmaking of the Patient's Experience		
CIP was insignificant <ul style="list-style-type: none"> • It doesn't hurt • It's temporary • "They forget about it" Treating patients as objects and carrying out procedures was described as "sterile and removed . . . disrespectful"	Viewed as serving a purpose and, as such, conditional: <ul style="list-style-type: none"> • It is necessary (for diagnosis, treatment, etc.) • It is life saving Degree of how problematic inflicting pain was varied among nurses, circumstances, patient population	It is <ul style="list-style-type: none"> • Unacceptable • Cruel • Torture

Table 13

Positioning of Nurses in the Remaking of Clinically Inflicted Pain

Viewing Clinically Inflicted Pain: The Remaking of Clinically Inflicted Pain		
CIP became something other than pain: <ul style="list-style-type: none"> • Necessary • Therapeutic • Helpful 	Various degrees to which the patient experience was accepted	Acceptance of reported report of pain: The patient has the pain s/he says has

Table 14

Positioning of Nurses When Attributing Significance versus Priority and When Treating Clinically Inflicted Pain

Attributing Significance Versus Priority and Treating Clinically Inflicted Pain		
Dismissal of CIP as: <ul style="list-style-type: none"> • Unavoidable 	<ul style="list-style-type: none"> • Utilizing various measures • Engaging the patient 	Pain management was <ul style="list-style-type: none"> • A mandate • Negotiated
Acquiescing of CIP: <ul style="list-style-type: none"> • Kids always cry 		

I framed CIP as a professional problem that required a personal solution. Positioning is the model to support this hypothesis.

Clinically Inflicted Pain Was Not an Ethical or Moral Issue

I returned to the data to answer the question whether the participating nurses viewed CIP as an ethical or moral issue. At least seven of the participating nurses used the verbiage “right” or “wrong” in the context of CIP. These words typically were placed within a feeling context. Nurses used the descriptor wrong when they went against patients’ wishes

(Participant 11), in cases of projected medical futility (Participants 4, 8, and 10), and when nurses felt that procedures were carried out in a “cold” or “cruel” way (Participant 8). The infliction of pain itself rarely appeared to be problematic.

For me, I have never really had any issues with that with administering or, um, um, doing a dressing change or whatever it is that I want to do, insert a Foley, if there is pain. I will always try to address it beforehand so we have the least amount of pain occur and we have the best-case scenario happen. —Participant 12

And: And, then, we’re torturing that woman because everything we do has no hope of good outcome for her. That makes, that just upsets me. It would upset me so much. Whereas, if you have 88-year-old grandma, or somebody with a cardiac arrest, or something like that, and you know that if you, you know, put her on a ventilator, and you drag her through hell, she has a really good chance of living, going back to her family, and living a good, happy life. That is like, feels very reasonable and acceptable. You know, it’s like I don’t, it’s like I’ll kind go, ‘Oh, ouch,’ you know, ‘I realize that hurts, and I’m sorry that hurts.’ But, I don’t feel like I’m participating in something that’s wrong inside my own, kind of, morality system, you know, of right and wrong. —Participant 8

At least four nurses (Participants 4, 8, 9, and 10) made references to morals or ethics and used the terminology of moral dilemma, moral injury, morality system, moral thing, and moral issues. Only Participant 10 referred to ethics. Participant 4 viewed lack of morals as problematic. Inflicting pain in the case of medical futility was viewed as wrong and placed in the context of “morality system” or “inner, moral compass” (Participant 8). Only Participant 9 linked inflicting pain to “moral compass” but added that it needed to be intentional.

Um, so there’s a moral compass in that. And like you don’t intentionally hurt someone without having, you know, a procedure or something that you have to do. That’s a very basic moral compass for me. Um, try and be kind. Try and be compassionate, um, yeah, respectful. I think pretty basic. —Participant 8

Participant 10 brought up the issue of “moral injury” (she reported having attended a lecture pertaining to moral injury in the recent past). She was disturbed by memories.

But then on some level, you know, what—the fact—I guess what it is, is that the patients that stay with you, like that child or like that elderly man or, you know, like

that—that burn patient that had 95 percent of his body burned, those for me clearly I have some moral injury then there because I—they have stayed with me and there is still pain when I think of that. So, I think probably that, you know, nurses do endure some moral injury. —Participant 10

And: Um, and—and that surreal quality and—I suppose not having a context or a story or truly knowing whether this—this man wanted us to do what we were doing, in a sense that was a moral dilemma. —Participant 10

Prior to conducting this study, I had thought of CIP as a moral issue; however, the data suggested otherwise. I conclude this section with a quotation from Participant 4 that highlights the importance this nurse gave to ethics and morals:

Well, ethics and morals are critical to all the decisions you make in your life. You gotta be clear on your ethics, and your values, and your morals to be able to make decisions in life. To me, the way we make decisions is a function of what we believe and what we hold dear—our ethics and our morals and our integrity. —Participant 4

Clinically Inflicted Pain Was Not a Pain Management Issue

The processes of transforming CIP (the unmaking of the patients' experience and the remaking of the CIP) created a reality for nurses that effectively changed CIP to mean something other than pain. For example, CIP was viewed as temporary thus inconsequential, which effectively eliminated the need for pain management. Transforming CIP explained the under or nonrecognition of CIP. In addition, I learned that some nurses equated the unavailability of CIP with CIP being untreatable. Undermedication was a likely occurrence when there was the nonrecognition or underrecognition of CIP. Given these findings, I argue that CIP not only is distinctly different from pain management, but that pain management is likely an issue based on the under or nonrecognition of CIP.

Methodological Considerations and Limitations

Within Glaser's grounded theory methodology, there was no predetermined sample size in this study. The study was based on 13 interviews, which was an acceptable number

for a qualitative study (Patton, 2015). All interviews were important. The length of the interviews proved to be insignificant; it was not uncommon to hear the most pressing experiences at the onset of the interview.

The representativeness of the study participants for registered nurses was difficult to estimate given that participants were recruited from different geographic areas within the United States. Assembling a full demographic, professional profile of all RNs in the United States was beyond the scope of the study. There was a large spread with regard to years of experience, educational preparation, and practice areas. I did not find significant differences between women and men, ethnic backgrounds, marital status, or level of education. However, years of experience affected the findings in one important aspect: Prior to undertaking the study, I had postulated that less-experienced nurses might be more empathetic with regard to CIP. The data did not support this hypothesis. But I noted a lack of explaining CIP in the two recently graduated nurses, which led me to conclude that nurses form an opinion about nursing over time.

A possible limitation of the study is related to the fact that I knew all of the participating nurses, either through my current employment or through social contexts. A personal relationship could have permitted more open sharing of experiences but also could have limited the sharing of personal views and/or conduct, as the participants might not have wanted me to know certain things about them. Knowing all of the participants could amount to a potential bias, as only a particular type of nurse might have agreed to participate. The impact of me knowing all participants is unknown. Another possible limitation could be construed from the references some of the participating nurses made to “cruel” nurses and the fact that they appeared to describe their conduct as an aberration. Within the group of

participating nurses, none described their conduct in a way that was suggestive of cruelty. It is perceivable that the participating nurses might represent a kinder fraction within nursing, but this remains unexplored.

Upon conclusion of the interviews during the coding phase of this research, I noticed that participating nurses often ended their statements with questions, such as “Does that make sense?” or “Do you know what I mean?” It was not clear whether these phrases were a matter of speech or represented real questions. However, within a research framework, these questions needed to be noted, and I needed to raise the question: How much of what participants were telling me was what they thought I wanted to hear? In the coding phase, I realized how much I influenced the flow of the interview and the topic nurses responded to by the type of questions and the timing of questions asked. At the onset of this research, my questions were frequently based on my preconceived notions about the topic of CIP, but were corrected as soon as this became obvious. Several omissions were noted during the coding phase. Some of these omissions were addressed in the section on future research. Upon conclusion of the study, I summarized the findings and articulated the theory of togetherness and positioning. I thought about CIP in new and unanticipated ways. As such, I have a certain degree of confidence that, despite my biases, I could hear what the participating nurses felt to be important enough to share. I developed a model that was quite different from where I started, and I thus concluded that despite my limitations, significant discoveries were made, and a model was developed that is worth exploring.

The study was based solely on interviews, which amounted to another methodological limitation. The data presented only what nurses were willing to share, what they believed

about themselves, and how they viewed their clinical practice. It was not known what nurses actually did in clinical practice.

Another limitation was that multiple interpretations of the data were possible. This limitation is inherent in qualitative research. Because of my use of the constant comparative analysis, I believe that I successfully managed subjectivity and speculative analysis. I based my hypothesis on the data, which allowed transparency. I believe that the findings of this study will need to be brought to a broader audience. Nurses will be the ultimate judges to decide whether the model is applicable to their practice. This perspective is supported by the Lincoln and Guba (1985) position that transferability of findings “cannot be made by an investigator who knows only the *sending* context” (p. 297). The receivers of this information—other nurses—must judge the extent of relevance to their practice settings.

I view this study as a contribution to the phenomenon of CIP and hope my findings spark enough interest for future research. Major strengths of the study were its findings (particularly the unmaking of the patients’ experiences and the remaking of CIP) and detailing the processes utilized by nurses to establish the rightfulness of a procedure. It was my hope to provide the basis for the development of instrumentation that will allow future research, particularly quantitative research, to complement my findings.

I utilized a number of strategies to ensure that the process of qualitative analysis was as rigorous as possible: I explored my biases and made those biases explicit prior to conducting the interviews. Throughout the coding phase, I wrote in a reflective diary (personal response documentation). Memos were written while journaling and analyzing the data. I had a whiteboard installed in my office and used notes stuck on a bulletin board to capture important aspects, which I arranged in a number of ways to make sense of the data.

Most important, however, was the process of comparative analysis, which I learned to utilize and appreciate. All findings were grounded in the data, as shown with selected quotations from the nurses. Large variations were noted among nurses, and the selected quotations were representative either of the views expressed by other participants or of an important variation that captured the complexity of the phenomenon of CIP. As such, the process of comparative analysis allowed me to differentiate between the overall picture and an important facet of the problem. Comparative analysis confirmed the consistency of certain themes and the conclusions I drew.

Evaluating grounded theory. Glaserian grounded theory (GT) is aimed at generating theory, and the quality of the hypothesis is assessed in terms of fit, relevance, workability, and modifiability. Fit, according to Glaser (1998), is another word for validity and answers the question of whether the discovered concept represents the pattern of data it purports to denote. Relevance addresses the question of whether the concepts relate to the true issues of the participants. Glaser explained, “Grounded theory generates a theory of how what is really going on is continually resolved” (p. 236). As noted above, the fact that I derived a different model at the conclusion of the study is evidence that I was able to shed at least some, if not all, of my preconceived ideas about CIP. I received preliminary feedback from some nurse friends, who recognized the proposed patterns and were intrigued by my findings. The ultimate test for fit and relevance will be determined by nurses. I intend to publish my findings, and in doing so, nurses will judge the fit and relevance. Workability reflects on how readily findings translate into practice; workability addresses variations in the data and predicts behavior. Modifiability captures how data modifies theory. I am confident

that my findings are workable and that the theory is modifiable. Similar to fit and relevance, it is for others to judge whether I succeeded.

Closing remarks with regards to methods. My entry into this research endeavor was a personal question: How come ordinary people perform cruel acts? This raised the question of whether my question affected my findings? My findings surprised me and shifted my thinking, and I know that the study has changed my position, not vice versa.

I was committed to transparency and readily submitted my work to scrutiny. Throughout this dissertation process, I tried to show my approach and explained my line of reasoning. However, the abundance of choices made explaining all decisions unworkable. I tried to be as transparent as possible so that readers can follow the research process and evaluate the decisions independently and judge how the choices affected the results.

Another issue is that I am a registered nurse and conducted research in a culture where I practiced. This created challenges of their own, as I discovered how blinded I was by a common nursing discourse. Breaking out of this mindset and recognizing nurses as separate from patients was the most difficult part of this research. I felt sympathy for the nurses and recognized their problems and struggles. This disabled an outsider's perspective but may have provided a deeper understanding of the issues at hand. At the core of this research is an acknowledgment that although nurses and patients were in the same room, their perceptions of what took place were quite different. It is my hope that the study captured the unique experience of nurses within the context of CIP. The implications of some of the findings need to be brought not only to nurses but also to patients. One of the major limitations of this study was the exclusion of patients, given that CIP is a co-created experience. A future study

could explore in greater depth the patient experience regarding CIP. All in all, I concluded that my nursing background made this study stronger.

Implications for Nursing

I believe the impact of this study, although important for nursing practice, is most important for nursing education. I base this statement on what participating nurses shared about their nursing instructors and based on my teaching experience in an associate degree (ADN) program in a local community college. There is an overemphasis on skills, the building of the professional nurse, and little attention is placed on the development of the nurse person. The proposed theory of togethering and positioning shows that preparing the nurse person should be an indispensable part of basic nursing education as it lays the foundation for responding to clinical situations. I am not advocating to conform nursing students and nurses but rather to provide a solid basis to respond to complex clinical situations, to emphasize self-awareness, teach ethics and morals, strengthen empowerment, teach how to relate and interact with other members in the health care environment, develop and demonstrate empathy and relating, and resolve emotional turmoil within the nurse person. Nursing instructors need to closely examine implicit messages transmitted to nursing students via conduct and verbal instructions and show students how to engage in meaningful dialogue with patients. In short, students need to learn to respond. As for clinical practice, I make suggestions in the section below.

What to do About Clinically Inflicted Pain?

I viewed CIP as a process, not as an entity. Czarnecki et al. (2011) recognized the lack of acknowledgement of CIP as possibly the most influential barrier to procedural pain management. The unmaking of the patient's experience and the remaking of CIP are deeply

ingrained processes within nursing practice. The consequences of untreated pain, including CIP, are increasingly recognized within nursing. Based on this study, the question then arose: How does one affect the processes of unmaking and remaking of CIP? Czarnecki et al. argued for a “cultural shift” (p. 98) to take place and proposed viewing procedures as “biopsychosocial experiences for the patient rather than simply a task to be completed” (p. 101).

I revisited the nursing pain management literature based on the assumption that there was a certain degree of overlap between CIP and issues related to pain management. There was an abundant body of nursing literature framing the issue of pain management within an ethical framework of autonomy, beneficence, nonmaleficence, and justice (e.g., Bernhofer, 2011; Czarnecki et al., 2011). The nursing literature further addressed pain assessment, pain management, and barriers to pain management. Pain management education was shown to affect pain management. The Institute of Medicine released the Blueprint for Pain in America in 2011; the American Nurses Association and American Nurses Credentialing Center were mentioned specifically in the section pertaining to nursing education. In this context, I concluded that pain management has been recognized, advocated for, addressed in initiatives, and recognized as an important teaching topic within nursing education. Czarnecki et al. addressed pain management of procedural pain (CIP) by way of clinical practice recommendations. Given these publications, tools, initiatives, and recommendations, it was difficult to understand why pain management remained a concern.

What could be done about CIP? In contemplating the question of how to address the issue, I looked at the history of pain as the fifth vital sign. Although pain assessment was successfully established in clinical practice, pain management remained a concern. The

American Pain Foundation (which ceased to exist in 2012) and the American Pain Society advocated for the issues related to pain and developed guidelines, position statements, and made practice recommendations. Licensing bodies such as the Joint Commission recognized the issue and proposed standards and outcome measures (Joint Commission, 2015).

Increasingly, there are calls for an administrative mandate, as education alone did not remedy pain management issues.

Participant 12, a nurse manager, reviewed scores from a Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey and noticed that scores related to pain management were “low.” She developed a simple action plan: Educate nurses, clarify expectations, and hold nurses accountable. Scores subsequently improved, and undertreatment became an issue for nurses. (Undertreatment is characterized by the underprescribing of analgesic medications by ordering providers, whereas undermedication is the underadministration of analgesic medications by nurses.) Initially, I thought this simple model proved to be effective given that Participant 12 held nurses accountable. I since have started to wonder whether the nurses responded to mere interaction. Regardless of what motivated nurses, the fact remained that nurses responded.

With regard to undermedication within the context of CIP, it appeared that accountability alone might be insufficient. Establishing and maintaining an institutional pain performance improvement plan is a Joint Commissions requirement; the Joint Commission itself had a blind spot with regard to CIP by excluding certain clinical situations such as X-rays. To address CIP within the context of pain management, supporting data are needed, which ultimately must be transcribed into quality indicators, as there is a greater emphasis on outcomes, and reimbursement is increasingly tied to outcomes. Measures of institutional

quality improvement are under scrutiny (Gordon, Dahl, Miaskowski et al., 2005; Gordon, Pellino, & Miaskowski et al., 2002). The following could be collected from patients in order to quantify the significance of CIP: What procedures were painful? How painful were the procedures? Was there a difference between a single versus repeated procedures? Did the duration of pain make a difference? Did you notice any long-lasting effects attributed to CIP? In addition to the physical pain, were any other factors important (e.g., emotions such as fear and anxiety)? Were you prepared, and if yes, how? What intervention, if any, was used to alleviate the pain? What worked and what didn't? How much were you able to affect the conduct of nurses? Was family allowed to stay or asked to leave? Did that impact you? Did you have any prior experience with painful procedures, and if yes, how did that affect you? What did pain mean to you?

Fagerhaugh and Strauss (1977) viewed CIP within the context of work and identified a number of factors that affected nurses. Answers to the following questions (designated as related to nurses' work by Fagerhaugh and Strauss) might facilitate defining the conditions surrounding CIP: How difficult was the procedure? How did that affect CIP? How long did it take to complete a procedure? Did the duration affect CIP? How many nurses were required to complete a procedure? How did that affect CIP? Is there a difference between a single or repeated procedure with regard to CIP? Was there urgency, and if yes, how did that affect CIP? What interventions were available to alleviate the CIP? Which were used? How effective were these measures? How much time was spent just managing the pain?

Fagerhaugh and Strauss further proposed factors related to nurses and patients: Did nurses' level of skill and/or experience with a procedure affect CIP? Did a nurse's work experience affect CIP? Did fatigue of the nurse affect CIP? Did the relationship to the patient affect CIP?

Did patient population characteristics affect CIP? Was the patient already in pain, and if yes, how did that affect CIP? Lastly, Fagerhaugh and Strauss proposed a number of organizational issues: What were patient loads? What was the acuity of patients? What was the size and rate of turnover of staff and/or patients? How well were the nurses trained? What back-up mechanisms were in place?

Organizations should develop and use policies and procedures that create pathways to hear and address the concerns of nurses. Management needs to have processes in place to evaluate CIP and to hold nurses accountable by means of documentation and performance reviews.

Once I raised the issue of an organizational response to CIP, a different question emerged: Why would nursing administration want to take up an issue when there is none? I do not know whether I have an answer to this question. I am concerned that the significance of CIP might make its way into clinical practice by way of malpractice lawsuits.

Undertreatment by providers is increasingly recognized in malpractice suits. I believe undermedication will, in time, become an issue as well. I believe patient education is needed. Although nurses are positioned to lead this educational initiative, the deeply ingrained beliefs of nurses with regard to CIP cause me to hesitate to advocate for nurses to take leadership. In addition, based on my experience as a patient and as someone familiar with medical settings, I believe information by itself is insufficient; there is a difference between information and motivation. Information might motivate some, but not all, nurses. I believe safeguards are needed (i.e., avenues of having concerns heard without fear of repercussions). To illustrate my point, I will share a personal experience:

I was referred for a specialized imaging study that required the injection of contrast medium. I had worked on the issues related for CIP for a number of years and wanted to test some of my hypothesis. The person in the imaging department started to prepare for an IV cannula insertion when I remarked that I wanted a topical anesthetic, to which she replied that was not available. After some back and forth, she stated, 'We only do that (topical anesthetic) if the needle stays in.' At that point, it became clear that I had been lied to and I insisted on the topical anesthetic being used. The person, by now irritated and upset, left the room. I was left with the fear that if I didn't comply the procedure would be canceled or that it would now take too long to complete the procedure and therefore I would need to reschedule. A radiologist came to talk to me and if memory serves me right, did inject a topical anesthetic before starting the IV access; he was clearly less skilled.

I believe that protocols, such as Conduct and Utilization of Research in Nursing in which nurses take the time to listen to determine patients' needs, are important contributions. Gittell et al. (2000) showed that with better relational coordination, better post-surgical pain relief was accomplished. To help influence patient outcomes related to pain management, I want to disseminate the findings of this study.

Future Research

This study focused on the experience of nurses and as such is one-sided. Many questions were raised in this dissertation. With regard to CIP, I propose the following three future research questions: First, what is the experience of patients? Second, what does the actual interaction between a nurse and a patient in the context of CIP actually look like, and how does this interaction between nurse and patient affect their experiences? And third, how come nurses inflict pain and are regarded as one of the most trusted professions?

The concepts of togetherness and positioning intrigued me as a workable and fitting model to describe current nursing practices. I have questioned my practice as long as I can remember and always sought meaning: What is it that I am doing? For whom am I doing this? Etc. I am looking back at nearly 40 years of working in the field of nursing in various

capacities and have seen changes in my profession and in myself. Togethering captures the experience of these years and allows me to remain true to myself, as togethering is fluid. I wonder about the possibilities of the question: Who or what am I as nurse? I wonder about the implication of defining the nurse as opposed to defining what nurses do. I want to emphasize the use of the first-person singular in these questions. Over the years, I have been exposed to a number of nursing theories but found it difficult to translate theory into practice. Togethering evoked a different response; togethering acknowledged me in where I am, as opposed to an imposed vision of what I am supposed to be. The participating nurses decided for themselves how to conduct themselves in a given clinical situation. All nurses described their conduct according to what they believed to be most important. As such, togethering and positioning describe the current state of affairs. The question that I would like to present to nurses at the conclusion of the study is: Who or what are you as a nurse? How does that translate into what you do?

Post Defense Reflections

Preparing the PowerPoint presentation for my dissertation defense required being concise, and thus I reached a higher level of abstraction and started to expand the theory of *togethering and positioning*. Although my research question was stated broadly, I focused on the question how do nurses do it (CIP)? The findings and discussion addressed this particular aspect as opposed to the broader question about the experiences of nurses in the context of CIP. It became evident that I had not articulated a *core variable* nor clearly outlined categories and their properties.

Before proceeding I would like to reflect on *emotions* and *empathy*. I noticed that the participating nurses frequently shared how they felt about inflicting pain, but I did not pursue

the aspect of emotions in the data analysis or in the discussion of the results. There was consensus among the participating nurses that nurses did not like to inflict pain, but the emotional component appeared to be unrelated to the aversion to inflict pain. Participant 8 spoke about patients on ventilators:

We have an 88-year-old grandma on the ventilator with end-stage lung disease, or she had a big stroke, and, then, we're torturing that woman because everything we do has no hope of a good outcome for her. That makes, that just upsets me. —Participant 8

And: So somebody comes in, and we're intubating them, and they're fighting and struggling, and we're tying them down, and we're giving them drugs, and they're scared, and they're fighting, and things hurt. You know, we're putting lines in, and we're, you know, he's tied to the bed on a ventilator, which I think is a horrible experience, you know... if they, there's every reason to think that they're going to have a good outcome, it's like, I feel good about doing that. —Participant 8

I postulated that emotions were the meeting point between the nurse person and the professional nurse. In reflection, I conclude that emotions are ways of knowing.

The role of empathy also became clearer:

And their kind of anguish that I am the cause of, but I am much more focused on their experience of it rather than my experience of me. —Participant 10

I postulate that empathy is a measure or degree to which another person's point of view is considered significant.

The theory of togetherness and positioning is based on the distinction between the nurse person and the professional nurse; the theory is in line with an earlier hypothesis that CIP is a professional problem that is left to a personal solution. I would like to delineate categories and the core variable of the discovered theory. Glaser and Strauss (1967/2009) noted that a category can stand by itself and that a property is a conceptual aspect or element of a category (p. 36). Both categories and properties are indicated by the data (not data itself). Many basic social processes were identified during the data analysis phase, including:

asserting authority; justifying CIP; filling the gap; transforming CIP; exercising power; realizing choices; what motivates nurses; choosing affiliation, etc. Properties of these categories were captured in Chapter 5 in Tables 5-14. Various categories (basic social processes) and properties are interrelated (e.g. without asserting authority it is impossible to exercise power or transform CIP); a nurse cannot transform CIP without a degree of justification. I had proposed that the coming together of the professional nurse and the nurse person explained and predicted the behavior of nurses. I had defined the professional nurse by education (or training), knowledge, and skills. I now identify the various processes as categories that are relevant to the professional nurse. I have developed a preliminary draft of these categories pertinent to the professional nurse (see Figure 2).



Figure 2. Core variable and categories of the theory of togethering and positioning.

I had defined the nurse person as a person who is also a nurse. I had proposed that the nurse person positions the professional nurse in the various processes, likely by utilizing the ways of knowing (Averill & Clements, 2007; Clements & Averill, 2004). With this said, an attempt was made to explain and predict the behavior of nurses in the context of CIP. I chose the process of transforming CIP as it was the most specific for CIP. I placed emotions within the broader context of ways of knowing. Empathy, as defined above, was sufficiently significant to have its own category. What follows is a first draft of the theory of togethering and positioning. This model illustrates the range of how nurses attribute significance versus priority. I anticipate that it will continue to evolve (see Figure 3).

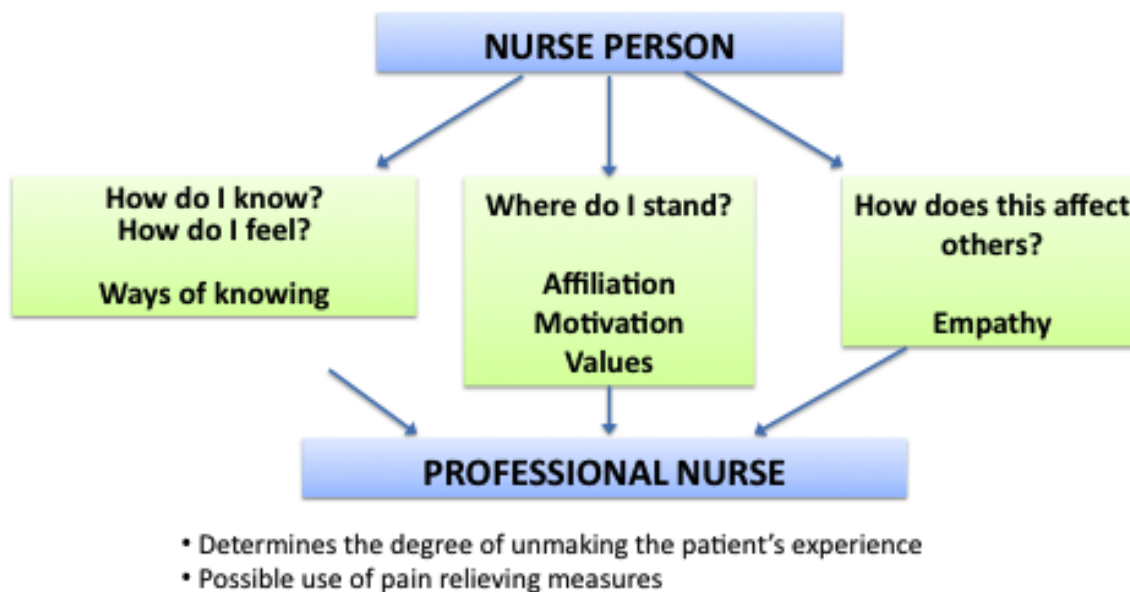


Figure 3. Preliminary model of togethering and positioning.

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Appendix A: Differentiation between Medical and Nursing (Nonmedical) Procedures

Much of the existing literature muddled medical and so called nonmedical presumed to at least include nursing procedures; medical and nonmedical procedures were equally likely to cause pain. I postulated that important differences existed between medical and nursing procedures that may or may not impact the incidence and/or severity of CIP. The differentiation was also necessary given the population under investigation (nurses).

Medical procedures typically were conducted by physicians or more recently by nurse practitioners and physician assistants. The purpose of medical procedures could be diagnostic, therapeutic, rehabilitative, and/or palliative. Medical procedures typically were recognized as a procedure and as potentially painful. Medical procedures could be single, isolated events but also needed to be repeated. Medical procedures typically required that information of potential risks was provided beforehand, and a written consent was obtained. Medical procedures had legal as well as fiscal implications. Medical providers (with prescriptive authority) had direct control over analgesic management during the procedure as those providers could order analgesic administration at any given time.

Nursing procedures were defined within the context of patient care and through the various nursing practice acts of individual states within the United States. Nursing procedures within a legal framework were the legal mechanism for nurses to perform functions, which otherwise could be considered the practice of medicine. The purpose of nursing procedures was similar to that of medical procedures and could be diagnostic, therapeutic, rehabilitative and/or palliative. Nursing procedures were subject to policies and procedures as well as to standards of care. These guiding measures typically were developed collaboratively by nursing, medicine, and administration in health care institutions. Nursing

procedures were standardized, thus created accountability (i.e., liability in form of malpractice and/or negligence). Nursing procedures could be single, isolated events but more frequently were characterized by their repetitive nature; e.g., repositioning of a patient typically is recommended every two hours. Nurses either follow providers' orders and/or performed various procedures within the context of nursing care (standards of practice that did not require a provider order). Nurses typically did not obtain a written consent. Nurses claimed to obtain verbal consent, but the literature, particularly the work done by Aveyard (2002; 2004; 2005) illustrated that consent is a contentious issue within nursing practice.

Appendix B: Coding of Parts of the Hinsch (1982) Publication

Coding of A. Hinsch (1982), The psychological effects on nursing staff working in a burns unit: page 25 (only coded section related to pain infliction).

<p>Working on a “burns unit . . . [the nurse] has to come to terms with the fact that she will be responsible for causing much of the pain”</p>	<ul style="list-style-type: none"> - Normal condition of work - Coming to terms: need for reconciliation - Responsible for causing pain <p><u>Note:</u> Responsibility is different from inflicting</p>	<p>Exception and the norm</p> <p>Ownership framed as responsibility</p> <p>Reconciliation</p>
<p>“No other aspect of nursing that requires staff to continually inflict pain on other human beings in the course of necessary treatment”</p>	<ul style="list-style-type: none"> - Isolation/singularity of the task - Continually inflict pain - Selective blindness of other painful aspects of nursing care &/or procedures - Part of necessary treatment: necessity and a cause 	<p>Special duty</p> <p>Perpetual</p> <p>Justification</p>
<p>“To be able to continue to work in a burns unit the nurse must adapt herself with dealing with other people’s pain, both physical and emotionally. What defense mechanism does she employ so that she can cope?”</p>	<ul style="list-style-type: none"> - Condition for work/ongoing challenge - Imperative of adaption - Process of adaption is both physical and emotional -> encompasses the whole person/nurse - Defense mechanism to enable coping 	<p>Process of adaptation</p>
<p>Hinsch citing Bernstein (1976), [The author makes the assumption that Hinsch agrees with Bernstein.] “Nurses who work in burn units have certain personality characteristics and attitudes to life that make them better equipped than others to</p>	<p>Difference in</p> <ul style="list-style-type: none"> - Personality characteristics - Attitudes to life - Difference are a “survival benefit” 	<p>Unique person vs. Specific personality profile</p>

<p>deal with the strain involved. Such nurses are more professional, more ambitious and a greater tendency toward counterphobic* reactions and a greater need to prove themselves. They tend to combine an old-fashioned devotion to duty with a semi-cynical view of life.”</p> <p>*relating to or characterized by a preference for or the seeking out of a situation that is feared [retrieved 5/31/12 from http://www.merriam-webster.com/medical/counterphobic]</p>	<p>Preparedness of some sort for this strain CIP = strain</p> <p>List of various characteristics (when compared to others)</p> <ul style="list-style-type: none"> - more professional - more ambitious - greater tendency toward counterphobic reactions (unique features) - combination of old-fashioned devotion with a semi-cynical view of life 	<p>Preparedness</p>
<p>“Bernstein also postulates that nurses pass through certain stages of adjustment and adaptation when first going to work in a burns unit. At first they tend to start with idealized expectations of the good effects they will produce but these are quickly threatened by the serious conditions and prognosis of many patients and their own inability to avoid causing pain and to effect recovery in all cases.”</p>	<ul style="list-style-type: none"> - Stages of adjustment and adaptation - Idealized expectations of the good effects they will produce - Illusion threatened: <ul style="list-style-type: none"> • good effects that are the result of nurses work • to effect recovery in all cases - Inability to avoid causing pain 	<p>Adjustment & Adaptation</p>
<p>“At first their defense mechanism are classic, e. g., projection and intellectualization but later to more positive defenses, mainly reliance on group support, more limited and realistic objectives, selective use of denial in hopeless or unalterable situations and acknowledgement of successes. Nurses who manage to obtain a final stage of commitment and acceptance remain in their units longer than colleagues in other wards.”</p>	<p>Gradual process from defense mechanism to</p> <ul style="list-style-type: none"> - Group support - Limited and realistic objectives - Selective use of denial - Acknowledgement of successes <p>Final stage:</p> <ul style="list-style-type: none"> - Commitment - Acceptance 	<p>Elements that foster perseverance</p>

<p>“Self-discipline and self-control of the nurse is definitely evident, because the nurse knows that due to the patient’s anxiety state, she cannot express her true feelings in front of the patient as this would only aggravate the situation. Feelings of repression and rationalization are more often employed by the nurse.”</p>	<ul style="list-style-type: none"> - Self-discipline - Self-control - [Nurses cannot express their true feelings] - Measures presumed necessary - In order to avoid aggravating a situation. 	<p><u>Restraint</u></p> <p><u>Presumed purpose</u> (outside of the nurses’ psyche)</p>
<p>“One tends to consciously block out some the screaming and abusive language used by the patients, especially when in pain. While inflicting this pain, in their minds the nurses are rationalizing, “I am doing this for the patient’s own good. The cure is often worse than the complaint.”</p>	<ul style="list-style-type: none"> - Nurses block out patients’ (negative) responses - Nurses are rationalizing. - Nurses doing this for the patient, while acknowledging the distress. 	<p><u>Dismissal</u> of (negative) patient responses</p> <p><u>Service to</u> another person (justification)</p> <p><u>Awareness</u> of distress.</p>
<p>Since nurses are not sadists, total repression of feelings is not possible.</p>	<ul style="list-style-type: none"> - Need to defend against possible preconceptions of who does this (unpleasant?, undesirable?) work. - Repression is only effective to a (unknown) degree. 	<p><u>Reprehensible</u> nature of CIP.</p> <p><u>Repression</u> is only effective to a (unknown) degree.</p>

Appendix C: Consent Form

The University of New Mexico

Consent to Participate in Research

HRRC# 14-105: The experiences of registered nurses who in the process of providing nursing care also inflict unintended pain: A grounded theory study.

05/16/2014

Introduction

You are being asked to participate in a research study that is being done by Jennifer B. Averill, who is the Principal Investigator (dissertation chair) and Hannelore (Hanna) Krieger, from the College of Nursing, University of New Mexico. This research is studying registered nurses.

You are being asked to participate in this study because you are a registered nurse (RN). A maximum of 30 RNs will take part in this study. While most participants will be from HI, where Ms. Krieger lives and works, RN's from across the United States may participate.

There is no funding for this study; it is a doctoral dissertation.

This form will explain the research study, and will also explain the possible risks as well as the possible benefits to you. We encourage you to talk with your family and friends before you decide to take part in this research study. If you have any questions, please feel free to contact one of the study investigators.

What will happen if I decide to participate?

If you agree to participate, the following things will happen: Hanna Krieger will set up a time and place to meet that is convenient to you. Hanna Krieger at that time will explain the study, will explain possible risks and benefits and will explain how your confidentiality will be protected. You will be asked to sign this consent form. An interview time and place will be set up that is convenient for you. An interview may last 30 minutes or 2 hours. Consistent with grounded theory methods, you may be asked for a follow-up interview at a later time.

How long will I be in this study?

The anticipated length of the study is one year. You may be enrolled for the entire duration in case a follow-up interview is requested.

What are the risks or side effects of being in this study?

(a) Loss of privacy and/or loss of confidentiality, (b) Potential emotional distress (disclosure of sensitive information during the interview that could raise uncomfortable feelings such as embarrassment, shame or guilt, (c) Therapeutic misconception (the hope that the study may change things). Other potential risks are stress, emotional distress and inconvenience.

For more information about risks and side effects, please ask the investigator, Ms. Krieger.

What are the benefits to being in this study?

You cannot anticipate any clear benefits. Potential benefits include (a) being able to discuss a potentially troubling experience with the researcher, (b) gaining insight and/or knowledge about yourself, working conditions etc., (c) escaping from routine and excitement about study participation, (d) satisfaction that the provided information may assist others.

What other choices do I have if I do not want to be in this study?

Participation is voluntary. You have the right to withdraw from the study at any time.

HRPO #: 14-105 Page 1 of 3 Version: 5/16/2014

APPROVED: 5/20/2014 OFFICIAL USE ONLY EXPIRES: 5/19/2015 The University of New Mexico Institutional Review Board (HRRC)

How will my information be kept confidential?

We will take measures to protect the security of all your personal information, but we cannot guarantee confidentiality of all study data.

Information contained in your study records is seen and analyzed by Dr. Averill (dissertation chair) and Ms. Krieger, doctoral candidate/co-investigator who is conducting the study. The University of New Mexico Health Sciences Center Human Research Protections Office (HRPO) is the Institutional Review Board (IRB) that oversees human subject research.

HRPO has the right to review study information if their office finds any reason to do so.

There may be times when we are required by law to share your information. However, your name will not be used in any published reports about this study. Participants will be informed of steps being taken by the co-investigator (Ms. Krieger) to ensure confidentiality.

Demographic data will be collected before the interview and will be assigned a random number; no direct identifier will be attached to the demographic data. Demographic data will be physically separated from the transcript of the interview. Demographic data will be stored in a separate locked file cabinet in Hanna Krieger's home. Hanna Krieger will be the only person to have access to the locked file cabinet. Upon completion of the study and defense of the dissertation, the demographic data and transcripts will be destroyed: paper copies will be shredded, computer files will be deleted and the trash will be emptied.

What are the costs of taking part in this study?

None

Will I be paid for taking part in this study?

No

How will I know if you learn something new that may change my mind about participating?

You will be informed of any significant new findings that become available during the course of the study, such as changes in the risks or benefits resulting from participating in the research or new alternatives to participation that might change your mind about participating.

Can I stop being in the study once I begin?

Your participation in this study is completely voluntary. You have the right to choose not to participate or to withdraw your participation at any point in this study without affecting your future health care or other services to which you are entitled.

Participants may withdraw from the study at any time.

Whom can I call with questions or complaints about this study?

If you have any questions, concerns or complaints at any time about the research study, Hanna Krieger, will be glad to answer them at (808) 371 0944.

If you need to contact someone after business hours or on weekends, please call (808) 371 0944 and ask for Hannelore (Hanna) Krieger.

If you want to speak with Ms. Krieger's dissertation chair, please call Dr. Jennifer Averill at 505-379-6159. If you would like to speak with someone other than the research team, you may call the UNMHSC HRPO at (505) 272-1129.

Whom can I call with questions about my rights as a research participant?

If you have questions regarding your rights as a research participant, you may call the UNMHSC HRPO at (505) 272-1129. The HRPO is a group of research reviewers from UNM and the community who provide independent oversight of safety and ethical issues related to research involving human participants. For more information, you may also access the IRB website at <http://hsc.unm.edu/som/research/hrrc/irbhome.shtml>.

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APPROVED: 5/20/2014 OFFICIAL USE ONLY EXPIRES: 5/19/2015 The University of New Mexico Institutional Review Board (HRRC)

CONSENT

You are making a decision whether to participate in this study. Your signature below indicates that you read the information provided. By signing this consent form, you are not waiving any of your legal rights as a research participant.

I have had an opportunity to ask questions and all questions have been answered to my satisfaction. By signing this consent form, I agree to participate in this study. A copy of this consent form will be provided to you.

Name of Adult Subject (print)

I agree to a possible second interview

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Date Yes No Initial Date

Signature of Adult Subject

INVESTIGATOR SIGNATURE

I have explained the research to the participant and answered all of his/her questions. I believe that he/she understands the information described in this consent form and freely consents to participate. _____

Name of Investigator/ Research Team Member (type or print)

(Signature of Investigator/ Research Team Member) Date

APPROVED: 5/20/2014 OFFICIAL USE ONLY EXPIRES: 5/19/2015 The University of
New Mexico Institutional Review Board (HRRC)

Appendix D: Recruitment Flyer

University of New Mexico

Registered Nurses (RNs) Wanted for a Research Study

Experience of RNs who in the process of providing care also inflict unintended pain

The purpose of this study is aimed at nurses who in the process of providing care also inflict unintended pain. The study is undertaken in the hope to develop a theory that (1) explains and predicts the behavior of nurses, (2) is useful and has practical applications, and lastly (3) adds knowledge to the discipline of nursing. It is anticipated that the study will take up to one year in which participating individuals may be interviewed at least once. It is anticipated that the interview will last at least thirty minutes to two hours and will be extended only with the explicit agreement of the participant. Repeated interviews might be indicated but will only be conducted with the explicit permission of the study participant. Interviews will be conducted in a location convenient to the participant.

With the exception of RNs who exclusively worked in pediatrics and or psychiatric settings all RNs are eligible (potential participants need to be at least age 18 and able to converse in English or German).

Benefits for participants are hypothetical – it is not known at this time what the findings of the study will. Participation will add to the knowledge gained from this study. No compensation will be provided.

To learn more about this research contact Hanna Krieger via email or telephone.

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Appendix E: Seeking Permission to Enter Letter

To Whom It May Concern:

My name is Hanna (Hannelore) Krieger and I am currently enrolled in the PhD program at the University of New Mexico, NM. I am in the process of conducting research for my dissertation. I am interested in the experience of registered nurses who in the process of providing care also inflict unintended pain (e.g. administering an injection, turning a patient in bed, inserting various tubes, etc.). The study has been approved by the Human Research Protection Office of the University of New Mexico (copy of document is enclosed). I am writing to request permission to post a recruitment flyer at your organization.

I want to recruit registered nurses for this study. Participation in the study is voluntary and interested RNs will be offered a consent form to sign (copy enclosed). If your organization will grant me approval, participating RNs will be interviewed outside the work environment and the interview will not affect work schedules. Participating RNs will remain anonymous and interviews will remain absolutely confidential. Your organization will also remain absolutely confidential. Data from the interviews will be analyzed and articulated in a theoretical format. No costs will be incurred by either your organization or the individual participant(s).

Your approval to post a recruitment flyer will be greatly appreciated. I will follow up with a telephone call or email next week and would be happy to answer any questions or concerns that you may have at that time.

If you agree, kindly sign below and return the signed form in the enclosed self-addressed envelope. Alternatively, kindly submit a signed letter of permission on your institution's letterhead acknowledging your consent and permission for me to post a recruitment flyer at your organization.

Sincerely,

Hanna (Hannelore) Krieger

Enclosures

- Approval of the Human Research Protection Office
- Recruitment flyer
- Consent form

cc: Dr. J. Averill, Primary Investigator, UNM

Approved by:

Print your name and title here

Signature

Date

Appendix F: Initial Questionnaire

- Do you remember (example of a nursing procedure that typically results in pain)
 - Giving your first injection
 - Inserting your first NG tube
 - Getting a fresh post-op patient out of bed?
 - Do you recall your feelings or thoughts? How do you feel about it today? Has anything changed since that time? And if yes, what has changed? Why do you think it changed? What do you think about the change?
- Did you seek advice, did some one give you advice and if yes, how did that affect you?
- How do you justify inflicting pain?
- Is there a difference when you perform a nursing procedure goes well or things go wrong and the patient is hurt as a result?
- What is it like when there is an order to do something to a patient and you do not agree with the order? Example: inserting a nasal feeding tube in a dying patient.
- You feel like something needs to get done, but the person asks you to stop.
- What if the patient does not have the insight to judge the benefit of a procedure (example cognitively impaired adult) and resists a procedure?
- Does it your perception of performing nursing procedures if you know the patient is dying and/or you perceive procedure as futile?
- What if a patient screams as a results of what you doing (dressing change, turning a patient in bed)?

- Have you ever thought, “This is too much, I don’t want to do this any longer?” How did you deal with that?
- Do you remember if the issue of inflicting pain ever came up in nursing school?

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