

**AN ETHNOGRAPHY STUDY OF NURSES'
CANCER PAIN MANAGEMENT
IN SRI LANKA**

Submitted by

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A thesis submitted in partial fulfilment of the requirement of the degree of

MASTER OF NURSING (RESEARCH)

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ACKNOWLEDGEMENTS

I would like to express my sincerest gratitude to my supervisors, Dr Colleen Rolls and Dr Michelle Campbell for their ongoing assistance, guidance and encouragement throughout the study. Without their continuous support my research goals would not have been achieved.

I would also like to express my gratitude to Mrs. S. L. H Vithanarachchi, Head, including other members of the Department of Health Sciences at the Open University of Sri Lanka as well as all others who gave their support to get this opportunity to fulfil my higher degree studies in Australia.

I would like to thank Open University of Sri Lanka and Distance Education Modernization Project of Asian Development Bank for giving financial assistance to do this study in Australia.

Many thanks also go to the Cancer Hospital in Sri Lanka, Director, Pain Clinic Consultant, Matron, Ward Sister, Nurses and colleagues, for their support and willingness to spend their time to contribute to this research. Their involvement was pivotal in my understanding of the research process and achieving my goals.

I gratefully acknowledge the Human Research Ethics Committees of Australian Catholic University and Sri Lankan Medical Association for ethics approvals and Director of Cancer Hospital who gave permission to conduct the study at Cancer Hospital.

Finally I would also like to thank my wife, Malkanthi, two sons Tharidu and Chamidu, our mothers and sisters who dedicated their lives for my higher education. Without their dedication it is hard to achieve this goal.

ABSTRACT

Cancer pain is a serious problem that requires specialised nursing knowledge to manage. This ethnography study explored the experiences and practices of cancer pain management among nurses at the Cancer Hospital, Sri Lanka. Data were collected at the Cancer Hospital in Sri Lanka during October 2007 to January 2008. Data consisted of participant observation of nursing practice in a cancer ward, semi-structured interviews with 10 participants and researcher diary. Analysis of data was undertaken with Richard's (2005) method of handling qualitative data and consisted of coding data initially and an integrative process to develop categories.

Findings identified Sri Lankan nurses have minimum cancer pain management practice because of a lack of resources, large number of patients to care for, shortage of nurses and unbearable workload in this hospital setting. Additionally the nurses are powerless as they have no autonomy in practice as well as no prospects of career promotion. They are stuck in a task oriented system that rarely acknowledges cancer patients' pain management needs.

It is anticipated that this study may lead to improve nursing pain management for cancer patients as well as curriculum change in nursing courses in Sri Lanka. Nursing curriculum change is required to include cancer pain management education as well as care of acute and palliative cancer patients. Additionally, the Ministry of Health in Sri Lanka needs to acknowledge the importance of palliative care service as well as pain management service and a recommendation is made to implement policies at the Cancer Hospital addressing these areas.

TABLE OF CONTENTS

STATEMENT OF AUTHORSHIP AND SOURCES	ii
ACKNOWLEDGEMENTS	iii
ABSTRACT	iv

CHAPTER ONE: INTRODUCTION

1.1	Introduction	1
1.2	Sri Lanka	2
1.3	Sri Lankan Health System	4
1.4	Nursing in Sri Lanka	7
1.5	Definition of pain	9
1.6	Justification of the study	10
1.7	Purpose of the Study	12
1.8	Summary and overview of the thesis	13

CHAPTER TWO: THE LITERATURE REVIEW

2.1	Introduction	15
2.2	Cancer pain	15
2.3	Assessment of cancer pain	18
2.4	The cancer nursing role	22
2.5	Nurses' knowledge and attitudes about cancer pain management	24
2.6	Barriers in cancer pain management	28
2.7	Cultural influences in cancer pain management	32
2.8	Cancer pain management in developed countries	35
2.9	Cancer pain management in developing countries including Sri Lanka	37

TABLE OF CONTENTS (Cont')

2.10	Nursing in Sri Lanka	41
2.11	Traditional health behaviors in Sri Lanka	43
2.12	Summary of literature	44

CHAPTER THREE: METHODOLOGY

3.1	Introduction	46
3.2	Nursing research	46
3.3	Qualitative (naturalistic) and quantitative (experimental-type) research	48
3.4	Rationale for selecting methodology	50
3.5	Ethnography: Methodology for the study	51
3.6	Symbolic interactionism: Theoretical perspective for the study	54
3.7	Role of the researcher	55
3.8	Data collection methods	56
3.9	Participant observation	57
3.10	Ethnographic interviewing	58
3.11	Sampling	59
3.12	Data collection	60
3.13	Data management	60
3.14	Data analysis	61
3.15	Ethical consideration	63
3.16	Conclusion	65

CHAPTER FOUR: RESEARCH PROCESS

4.1	Introduction	66
4.2	The Researcher	66

TABLE OF CONTENTS (Cont')

4.3	The field	67
4.4	Entering the field	69
4.5	Participants	70
4.6	Observation of participants	71
4.7	Field notes	72
4.8	Interviewing	73
4.9	Reflective diary	75
4.10	Evaluation of research	76
4.11	Conclusion	78

CHAPTER FIVE: FINDINGS

5.1	Introduction	79
5.2	The nurse in Sri Lanka	81
5.3	Health care situation in Sri Lanka	88
5.3.1	Resources for cancer management	88
5.3.2	Ward environment	89
5.3.3	Patients	90
5.3.4	Shortage of staff	92
5.3.5	Management influences	94
5.4	Nurses are powerless	95
5.4.1	Knowledge deficits	95
5.4.2	Working under medical directions	98
5.4.3	Nurses' attitudes and beliefs	100
5.5.	Stuck in an unchanging situation	102

TABLE OF CONTENTS (Cont')

5.5.1	Increasing workload	102
5.5.2	Task orientated nursing	104
5.5.3	Minimum career opportunities	105
5.6	Nurses' cancer pain management	106
5.6.1	Nurse-related factors	106
5.6.2	Medical-related factors	111
5.6.3	Patient-related factors	114
5.7	Conclusion	119

CHAPTER SIX: DISCUSSION AND CONCLUSION

6.1	Introduction	120
6.2	Health care in Sri Lanka	120
6.3	The nurse in Sri Lanka	123
6.4	Cancer pain knowledge and attitudes among nurses	126
6.5	Nurse cancer pain management practices	129
6.6	The barriers to nurse cancer pain management	131
6.7	Therapeutic and non-therapeutic cultural pain management therapies for cancer patients	134
6.8	Limitations of the study	135
6.9	Conclusion	136
6.10	Recommendations	137

MY REFLECTIVE DIARY	139
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REFERENCES	141
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TABLE OF CONTENTS (Cont')

APPENDICES	152
APPENDIX 1: ACU HREC Approval	152
APPENDIX 2: Cancer Hospital Director's Approvals	153
APPENDIX 3: Sri Lanka Medical Association HREC Approval	155
APPENDIX 4: Recruitment Advertisement	156
APPENDIX 5: Information Letter	157
APPENDIX 6: Consent Forms	159
APPENDIX 7: Participant Observation Theme List	161
APPENDIX 8: An Interview Theme List	162

CHAPTER 1

INTRODUCTION

1.1 Introduction

All persons have experienced pain at some point along the life continuum from birth to death, especially while in hospital. Similarly every nurse gets to experience managing a patient with pain at some point of his or her nursing career (Matthews & Malcolm, 2007). Nurses care for patients with cancer in various settings. Although some nurses can make a choice to work in an oncology unit, almost every nurse will, at some time or another, care for a patient with cancer and some of them might feel ill-equipped or uneasy with this situation. Therefore nurses' cancer pain management approaches are important in clinical settings to effectively manage patients' cancer pain.

As a result of the significant developments in the field of health, there have been improved health outcomes as well as raised public expectations of health care services. Because of these developments, it is necessary for nurses to have up to date knowledge and skills to provide high quality care to individuals and communities with whom they work. To develop such knowledge, nursing research is of paramount importance to the nursing profession (Gerrish & Lacey, 2006). This research topic: 'An exploration of nurses' cancer pain management in Sri Lanka' may help to enrich nurses' knowledge regarding cancer pain management and its importance to the profession.

1.2 Sri Lanka

The study setting is Sri Lanka a small Island in the Indian Ocean located off the southern tip of India. Land mass size consists of 65,610 square kilometres with 430 kilometres diameters from north to south and widest of 225 kilometres. There are also a large number of smaller islands around the main land mass (Department of Census and Statistics, 2007). The country is similar in size to Ireland (Williams, Chandler, Ranwala, De Silva, & Amarasinghe, 2001), but has a much larger population of 20.6 million (Department of Census and Statistics, 2007). Sri Lanka can claim a long history of civilization based on irrigation and agriculture of over 2500 years (de Silva, 1981).

The name of the country changed during the British colonial period from 'Sinhaya' to 'Ceylon' in English or 'Lankawa' in Sinhalese (de Silva, 1981). Since the country gained independence in 1948, the name has changed again to the present 'Sri Lanka' in 1972 (de Silva).

Historically, Indo-Aryan emigration from India in the 5th century B.C. came to form the largest ethnic group in Sri Lanka today, called the Sinhalese (de Silva, 1981). The Sinhalese community comprised 73.8% of the population in 2001 (Department of Census and Statistics, 2007). Tamils, the second-largest ethnic group on the Island, are originally from the Tamil region of India and emigrated between the 3rd century B.C. and A.D. 1200. They comprised 8.5% of the population (4.6% Indian Tamil and 3.9% Sri Lankan Tamil) in 2001. The Tamils are primarily Hindus and the Sinhalese are predominantly Buddhist (69.1%).

On February 4th 1948, after pressure from Ceylonese nationalist leaders which briefly unified the Tamil and Sinhalese, Ceylon became a self-governing dominion of

the Commonwealth of Nations separating from British rule (de Silva, 1981; Department of Census and Statistics, 2007).

The description of the country from the census in 2001 is that Sri Lanka is a multi-ethnic, multi-linguistic and multi-religious country. Multi-ethnic community comprise a small group of Sri Lankan Muslims and other unspecified ethnic groups. Sri Lankans are multi-linguistic with the official and national language Sinhalese spoken by 74% and Tamil is also considered as the national language spoken by 18% of the population. English is commonly spoken in government and is spoken competently by about 10% of the population. Sri Lankans are also multi-religious with Buddhism being the most prominent religion of the country. Additionally, multi-religious communities consists of approximately 8% Muslim, 7.1% Hindu, 6.2% Christian and unspecified 10% in Sri Lanka (Department of Census and Statistics, 2007).

Though Sri Lanka suffered a 'brutal' civil war that began in 1983, the country saw the gross domestic product (GDP) growth average 4.5% in the last 10 years with the exception of a recession in 2001. In 2007, the Sri Lankan economy recorded a growth of well above 6 per cent for the third consecutive year for the first time since independence. This demonstrates that Sri Lanka has now moved on to a higher growth path of above 6 % per annum from the historical average of around 4-5 per cent (Central Bank of Sri Lanka, 2007).

In late December 2004, a major tsunami took about 31,000 lives; left more than 6,300 persons missing with 443,000 persons displaced and destroyed an estimated \$1.5 billion worth of property (Department of Census and Statistics, 2007). This disaster influenced all aspects of Sri Lankan development including the health system. On the other hand, the struggle by the Tamil Tigers of the north and east for an

independent homeland continues to cast a shadow over the economy (Central Bank of Sri Lanka, 2007).

In Sri Lanka, there is a strong tradition of both men and women working, with men focusing more on income opportunities and women focusing on the household (Little & Sabates, 2008). Currently, women's participation in the paid labour force is significant, although not evenly distributed and concentrated in professions such as nursing, teaching, tea picking and garment construction (Central Bank of Sri Lanka, 2007; Department of Census and Statistics, 2007). Within the home, regardless of their engagement in paid labour, women and girls do all food preparation and most other domestic work. In general, the status of women has always been and still is lower than that of men in the traditional conservative society of Sri Lanka. Although total empowerment of women in the economic, social and political spheres is still an ideal, a noteworthy increase in the positive direction has been recorded during the recent past (Department of Census and Statistics, 2007).

Due to the development of a free health system, life expectancy at birth is currently 74.97 years (2008 est.), crude birth rate 16.63 births/1,000 population (2008 est.) and crude death rate 6.07 deaths/1,000 population (2008 est.) (Department of Census and Statistics, 2007). According to the Department of Census and Statistics there are major health problems in Sri Lanka such as malnutrition, addiction to liquor and drugs, increase of female-headed households, elderly population and suicides.

1.3 Sri Lankan Health System

A rich diversity of health systems are practised in Sri Lanka such as western medicine, ayurveda, unanni, siddha and homeopathy. Western medicine is the main

sector which caters for the needs of the majority of people. The Sri Lankan health care system includes both public and private sectors.

The public health care system is a free government service under the Ministry of Health. It comprises a western and ayurvedic system and provides the entire range of preventive, curative and rehabilitative health care for nearly 60% of the population (Department of Health Services-Sri Lanka, 2003). The private sector consists of practitioners in all types of health care, allowing people to seek the care of their choice. According to the Department of Health Services (2003), the private sector provides mainly curative care which is estimated at 50% of the health care of the population, largely concentrated in urban areas.

At the beginning of 1985, a collaborative program of the University of Colombo and the Australian National University employed both demographic and anthropological methods to study almost 11,000 persons in seven localities of southwestern Sri Lanka. The study found that the major geographical mortality differences are no longer urban-rural but between the richer and poor areas of Colombo (Caldwell, Gajanayake, Caldwell, & Peiris, 1989). According to the study, traditional medicine is still widely practiced, with exorcism a major cause of health expenditure in many families. The key findings of this study highlighted modern medicine can now usually be obtained at a convenient location and more cheaply than traditional health care. Traditional healers frequently refer cases to western medicine and to hospitals. However, most changes of treatment are decided by the sick person themselves and their relatives with unsuccessful treatment changed on average of five days (Caldwell et al.).

Large public facilities experience overcrowded out-patient departments (OPDs), long queues and bed occupancy rates over 100%; problems exacerbated by the lack of

a rigid referral system and bypassing small community health centres (Caldwell et al., 1989). The authors also suggest that high patient loads contribute to cursory consultations at public OPD facilities causing many patients to seek out-patient (OP) treatment at private clinics and pharmacies. Often patients choose to visit public doctors practising privately outside official public hours.

Wanasinghe (1995), investigated health care facilities by utilizing a variety of data sources to examine the distribution and use of health care facilities. Primary data on health conditions was obtained from surveys conducted in welfare camps for displaced persons in the north-central province and on urban street children in the city of Colombo. The reported study also draws on published and unpublished secondary data to account for spatial variations in the distribution of health care and to identify underserved areas. According to the author, the marked concentration of hospitals shows an urban bias in the distribution of health care facilities in Sri Lanka. The author pointed out these services are not accessible to all, but they are generally affordable because health care facilities are provided free of charge. However, Wanasinghe further highlighted as in many Third World countries, there is a need to provide more health care facilities in the remote rural areas, to encourage more qualified key health personnel to work in the periphery areas and actively involve the user communities (urban and rural poor) in the planning, design, implementation and management of health programmes. The study concluded there is a need to enhance quality and consistency of care to boost public confidence in the lower levels of the health care hierarchy in Sri Lanka.

Quality assurance has not been a focus of health care in Sri Lanka as was highlighted by a project that attempted to implement a quality assurance process at a government hospital (Withanachchi, Karandagoda, & Handa, 2004). The researchers

initially implemented data gathering strategies and encountered resistance from the staff, who were not supportive of changing the existing conditions and work formula. Implementation was affected by financial constraints, with inadequate funding by the Ministry of Health.

Under-funding of the government health sector is widespread and has started to worsen in recent years, with the expenditure relative to GDP dropping to 1.2% (Withanachchi & Uchida, 2006). The burden of under-funding has mainly affected preventive and promotive services and lowered levels of curative facilities due to the inadequacy of guidelines and standards for prioritization. According to Withanachchi and Uchida, excessive demand is leading to widespread rationing especially at tertiary-care hospitals, as patients tend to bypass poorly funded local facilities with poor service quality.

The health services in the public sector are characterized by a very busy and overcrowded system of National, Provincial, General and Base hospitals and a widely spread network of district hospitals and healthcare units operating at lower levels of utilisation and occupancy in Sri Lanka. According to World Health Organization (2008), management of the health care system needs to be improved by a clearer conceptual basis for coordination of health services, coupled with adequate resource allocation and the strengthening of existing institutions.

1.4 Nursing in Sri Lanka

Sri Lankan nurses complete three years General Nursing Diploma at Nursing Training Schools (NTS). The education is under the direction of the Department of Health Services (Department of Health Services-Sri Lanka, 2003). Nurses are registered with the Medical Council due to a lack of a specialised nursing council. The

three years general nursing curriculum consists of 20 theory courses based on traditional subjects, such as medical, surgical, paediatric, psychiatric, and maternal nursing. The major aim of the program is to prepare general nurses for employment in the national health care system.

Currently, there are eleven Schools of Nursing throughout Sri Lanka providing the three year general nursing education program, with more than 1,000 nurses completing these programs each year (Department of Health Services-Sri Lanka, 2003). Registered nurses are mostly employed in government hospitals including the Cancer Hospital. Post registration training in nursing specialities such as cancer nursing is currently not available. Nurses do not have any education on pain management in their basic training or continuing professional development sessions once qualified and employed (Hiscock & Kadawatage, 1999).

The Post-Basic School of Nursing (PBS) and National Institute of Health Sciences (NIHS) conducts post basic training programs for nursing personnel such as Teaching and Supervision, Management and Supervision, Midwifery and Public Health Management programs (Department of Health Services-Sri Lanka, 2003). After completing their Post-Basic Diploma, graduates may be promoted as Ward Sisters (Ward Managers) and Tutor Sisters (Nursing Teachers). In-service training programs are conducted by respective employer organizations for most categories of staff, including nurses (Department of Health Services-Sri Lanka, 2003).

Throughout the history of nursing in Sri Lanka, nurses have been involved in delivering health care services in terms of caring for patients, preventing illnesses and promoting the health status of the nation. However, it is acknowledged that the nursing profession has been considerably delayed in asserting its professional status within the health sector in Sri Lanka (Jayasekara & McCutcheon, 2006).

Medical Officers command a very high standing within the professional sector and especially health care sector in Sri Lanka. The concept of producing graduates in related health fields such as Nursing, Radiography, Pharmacy and Physiotherapy has been given a very low priority with an almost lack of encouragement from the entrenched medical profession (Fernando, 1999).

There has been minimal effort to improve the standards of nursing education primarily due to inadequate involvement of those responsible for improving health services in Sri Lanka. Nursing services and nursing education in Sri Lanka are under scrutiny because nurses today are showing increasing concern about their professional roles, education and status than earlier (Jayasekara & McCutcheon, 2006). According to the authors, nurses need a solid university based education, assertiveness skills, specialised knowledge and skills in different fields of nursing including oncology and technical competence to work within the rapidly changing health care world in Sri Lanka.

1.5 Definition of pain

A formally accepted definition of pain is that it “is an unpleasant sensory and emotional experience, associated with actual or potential tissue damage or described in terms of such damage” (International Association for the Study of Pain (IASP), 1986, p. 217). This definition highlights not only the pathophysiological origin of pain but also the psychological aspects of the experience of pain. Pain is one of the most feared consequences of cancer experienced by patients (Bernardi, Catania, & Tridello, 2007; Howell, Bulter, Vincent, Watt-Watson, & Stearns, 2000).

A well-recognized definition of pain within the nursing profession by McCaffery (2000) states that “pain is whatever the experiencing person says it is, and whenever

the experiencing person says it does” (p. 2). This definition emphasises the subjective dimension of the pain experience. This subjective nature of pain experience therefore presents important challenges for pain assessment, measurement and management.

According to Maassen and Patiraki (2006), definitions of pain are varied and only the patient can identify his or her pain definition and his or her own experience of pain. The authors further pointed out that the multidisciplinary team members may interpret this message differently and it can result in delayed diagnosis and treatments therefore leading to suboptimal care.

1.6 Justification of the study

Many patients have experienced pain in their life, especially while in hospital. Nobody wishes to be in pain. Although many specialized pain management teams are available in most countries to assess and fulfil the needs of patients with pain, no such service was available in Sri Lanka until 1999. The first Cancer Pain Clinic was established at Cancer Hospital, Maharagama in 1999 which was affiliated with the Pain Clinic at the Royal Marsden Hospital, London (Williams et al., 2001). Another Pain Clinic was established in the National Hospital of Sri Lanka (NHSL). These two Pain Clinics alone cannot give sufficient services to improve the knowledge of pain and pain management for the health care team members in Sri Lanka.

The World Health Organization (WHO) and other authorities highlighted that one of the main barriers to effective cancer pain control in developing countries is a lack of education for health care workers (Joranson, 1993; Stjernsward, 1988; World Health Organization, 1990). The problem of education in Sri Lanka was highlighted by a survey of 100 nurses’ attitudes towards effective cancer pain control (Williams et al., 2001). The authors further highlighted that cancer pain control in Sri Lanka is

made difficult by the lack of pain education and specialisation, pain treatment clinics and palliative care services. A study investigating knowledge level about cancer pain management among Sri Lankan nurses is therefore warranted.

Sri Lankan cancer treatment facilities are mostly centred on the Cancer Hospital at Maharagama, a suburb of the capital city of Colombo. This hospital has approximately 700 inpatients beds and offers the full range of cancer treatment for the entire Sri Lankan population free of charge, including surgery, radiotherapy and chemotherapy. Total number of patients admitted to this hospital was 28,671 in 2006 (National Cancer Institute, 2006). According to the National Cancer Institute statistical review, bed occupancy rate was 109% and bed turnover rate 12% in 2006. There were 2.95 beds for 1000 persons requiring for cancer treatment in 2000 (National Cancer Control Programme, 2000).

According to Department of Census and Statistics (2007), Sri Lanka has approximately 21 million people and an estimated 18,000 new cases of cancer in 2002 (Ferlay, Bray, Pisani P, & Parkin, 2004). Sri Lanka has a National Cancer Control Programme, a National Cancer hospital and seven centres with radiotherapy facilities attached to the general government hospitals (one centre is private). Patient demand for cancer therapy far exceeds available services. Cancer prevention, registration, early detection, palliation and training, are either limited or not well developed (Programme of Action for Cancer Therapy (PACT), 2008).

Very few patients with chronic pain have access to palliative care programmes in Sri Lanka. While there is access to opioids, usage is limited because there is a severe shortage of health professionals trained including nurses, to use those (Programme of Action for Cancer Therapy (PACT), 2008). In other developing countries including Sri Lanka, the availability of drugs such as morphine is strictly controlled by law, due

to a fear of misuse; meaning that access to pain medication is desperately limited (Programme of Action for Cancer Therapy (PACT)).

According to the Annual Report of the International Narcotics Control Board (INCB) issued in Vienna in March 2008, Europe and North America accounted for 89% of the global consumption of morphine in 2006. Developing countries, which have 85% of the world's population, consumed only 6% of the worldwide morphine distribution. The INCB noted many reasons for the low consumption, including inadequate medical education of health professionals, attitudes, regulatory impediments and economic concerns (International Narcotics Control Board (INCB), 2008). The INCB President further pointed out in their report that governments should be focused on measures to develop demand for pain-relief medications in line with the recommendations and guidelines of INCB and the World Health Organization.

This study will be significant for a number of reasons. Firstly, assessing registered nurses level of knowledge will convey how up-to-date their knowledge base is. Secondly, the existence of knowledge deficits will highlight the need for ongoing education, staff development and subsequent guidelines and policies for management of patients who are suffering from pain. Implementation of guidelines could ultimately improve the quality of life and pain outcomes and reduce occurrences of mismanagement of pain in this vulnerable patient group. Finally, results may raise nurses' awareness of the appropriate standards of caring for patients with cancer pain.

1.7 Purpose of the Study

The main aim in this study is to explore the experiences and practices of cancer pain management among nurses at the Cancer Hospital, Maharagama, Sri Lanka. The specific objectives of this study are as follows:

1. explore the cancer pain knowledge and attitudes among nurses in Sri Lanka;
2. identify nurse cancer pain management practices;
3. identify the barriers to nurse cancer pain management;
4. identify therapeutic and non-therapeutic cultural pain management therapies used by cancer patients in Sri Lanka.

It is anticipated that this study may lead to improved nursing pain management for cancer patients as well as curriculum change in nursing courses in Sri Lanka.

1.8 Summary and overview of the thesis

The thesis consists of six chapters. Chapter one describes the purpose and rationale for the study, background to the study and the significance of cancer pain research for nurses in Sri Lanka.

Chapter two presents the literature review which directly relates to the purpose and objectives of this study: ‘exploring nurses’ cancer pain management practices in Sri Lanka’. This chapter presents evidence from various studies from developed and developing countries. The chapter includes Sri Lankan background literature related to nursing and cancer pain management from a broad perspective.

Chapter three and four outlines ethnography as the methodology used in the study. These chapters provide a detailed description and justification of the research design and methods of data collection, which include participant observation, semi-structured interviews and researcher’s reflections. The chapters also provide details of the sample, the procedures, the measures and the process of data collection and data management using NVivo software.

Chapter five presents the findings of the study presenting the major category and sub categories that emerged in the context of the analysis using Richards method of handling qualitative data (2005).

Chapter six is a discussion of the results of this study. Study objectives are overviewed and discussed in line with research findings. This chapter further includes recommendations that can be drawn from the findings, and suggests how these may be applied to develop improvements in nursing care and nursing research related to cancer pain management in Sri Lanka. Additionally limitations of the study are identified in the chapter.

CHAPTER 2

THE LITERATURE REVIEW

2.1 Introduction

The focus of this literature review directly relates to the purpose and objectives of this study: 'exploring nurses' cancer pain management practices in Sri Lanka'. Sri Lankan background literature is also included related to nursing and cancer pain management from a broad perspective.

Literature published between years 2002 to 2008 was accessed for the study and a small number of relevant articles dated prior to 2002 are also included due to their importance. Due to few relevant articles about cancer pain management in Sri Lanka, the researcher reviewed Asian literature as well as the international literature. Material for the review was obtained by utilising a number of sources including books, journals, and electronic databases. Subject areas including cancer pain, cancer pain assessment, the cancer nursing role, cancer pain knowledge and attitudes among nurses, barriers to effective cancer pain management, cultural influences in cancer pain management, cancer pain management in developed and developing countries and health behaviour and nursing in Sri Lanka were accessed and reviewed.

2.2 Cancer pain

Cancer pain is a major problem in the health sector all over the world. Many patients with cancer-related pain suffer from severe pain (2004). If left untreated, cancer pain can influence overall quality of life, the ability to work, to interact with other people and to cope with illness (Tafas, Patiraki, McDonald, & Lemonidou,

2002; Vallerand, Collins-Bohler, Templin, & Hasenau, 2007; Vallerand, Hasenau, & Templin, 2004). A number of guidelines for effective pain relief have been published but there are still patient and staff-related barriers to successful pain control not only in Sri Lanka, but all over the world (Bostrom et al., 2004).

There are many studies that highlight cancer pain management as a problem. Van den Beuken-van Everdingen et al. (2007) investigated the prevalence of pain in cancer patients according to the different disease stages and types of cancer. A systematic review of the literature was conducted. Fifty-two studies were used in the meta-analysis of the past 40 years from 1966 to September 2005. The pooled data from the 52 articles highlighted that pain was prevalent in cancer patients: 64% in patients with metastatic or advanced stage disease; 59% in patients on anticancer treatment and 33% in patients after curative treatment. More than one-third of the patients with cancer pain in the reviewed articles graded their pain as moderate or severe. The authors concluded that cancer pain is still a major problem globally.

According to the finding of a recent study by Cheville, Beck, Petersen, Marks, and Gamble, (2008), cancer pain management remains problematic. A consecutive sample of community-dwelling outpatients receiving care at the Mayo Clinic Cancer Centre in Rochester, United State of America (USA), was recruited for the study between July 21st and 28th, 2004. Two hundred forty four patients undergoing cancer outpatient treatments were administered a questionnaire exploring cancer-related symptoms. Eighty-three per cent of respondents reported at least one cancer-related symptom, sign, or functional problem with over 70% patients identifying cancer pain as an issue for them. This recent study therefore indicates the significance of the continuing problem of effective cancer pain management.

It is known that pain is a multifaceted phenomenon which mainly involves biological, psychological and social consequences (Ahles, Blanchard, & Ruckdeschel, 1983; Menefee & Monti, 2005). According to Ahles et al., cancer pain can be considered to consist of five components which are physiological: the organic etiology of the pain; sensory: the location of pain, its intensity and its quality; affective: emotional response to pain; cognitive: individual thought processes of the meaning of pain and behavioural: behaviour related to pain. McGuire (1995) and Spross and Burke (1995) added additional dimensions of socio-cultural: demographic characteristics and ethnic backgrounds and spiritual: holistic response to pain to the five components. These seven components provide the foundation for assessment and management of cancer pain. Maassen and Patiraki (2006) argued that nurses are the key health care workers who need to consider these components in the assessment and management of cancer pain. This is because nurses spend more time with cancer patients than other health care workers in the multidisciplinary team.

The psychological consequence of unrelieved cancer pain can be devastating because patients often lose hope once pain emerges, believing that pain signals the progress of their disease (Zaza & Baine, 2002). Several databases were systematically searched using the key words including psychological distress from 1966 to 2000 by Zaza and Baine who undertook a critical review of the literature on cancer pain and the associated psychosocial factors. Nineteen studies on psychological distress were examined for an association between cancer pain and psychological distress including mood disturbance, mood states, depression, distress, emotional distress, psychological well-being, depressive feelings, fear, anxiety, and worry. Fourteen of the 19 studies found a significant association between cancer pain and psychological distress. Higher levels of distress were associated with higher levels of pain therefore attention to

psychological issues such as affective distress, coping and beliefs about cancer are important aspects of managing cancer pain (Menefee & Monti, 2005). In stable disease states, uncontrolled pain prevents patients from working and enjoying recreation. Adequate pain control, on the other hand, can contribute to an improved quality of life by lessening a patient's sense of suffering, increasing activity and improving sleep and appetite (Ferrell, Ferrell, Riner, & Grant, 1991).

Cancer pain is still a major problem and many patients suffer from it worldwide. The psychological effects of cancer pain are many and include depression and a reduced quality of life.

2.3 Assessment of cancer pain

Assessment is the basic step of any strategy for cancer pain management. Cancer pain assessment is still a contentious issue with multiple pain tools currently available. It is important to measure pain, document and assess the outcome of established new treatments (Caraceni, 2001). This occurs through the collection of pain assessment data that is organized, systematic and ongoing (Maassen & Patiraki, 2006). According to McGuire (1995), the purpose of a comprehensive pain assessment are to identify patients who have pain and those who are at risk of pain. Additionally, to describe the nature of pain and its influences on the patient and family as well as to help built a good therapeutic relationship between nurses and patients. Assessment consists of collecting basic information that helps to select interventions and provides evaluation information on the effectiveness of the intervention.

In the 1980s, studies highlighted a lack of information about assessment and pain control among nurses (McCaffery, Ferrel, O'Neil-Page, Lester, & Ferrell, 1990). Caraceni (2001) emphasized assessment and evaluation are the first steps of cancer

pain management. Caraceni further pointed out the importance of pain tools that are helpful in the assessment of cancer pain such as the Visual Analogue Scale (VAS), Verbal Rating Scale (VRS), Numerical Rating Scale (NRS) and some multidimensional tools including Brief Pain Inventory (BPI) and the McGill Pain Questionnaire.

Inadequate pain assessment represents a highly prevalent barrier to effective cancer patient care management (Vallerand et al., 2004). The management of cancer pain depends on a comprehensive assessment of the relationship between pain and the disease as well as the impact of the pain and co-morbid conditions which may influence quality of life. It is acknowledged that standard nomenclature and a multidimensional approach are essential components of a comprehensive assessment (Lesage, Russell, & Portenoy, 1999). However, this is not currently occurring according to the literature.

The early research on pain stimulus and intensity observed that individuals would give subjective responses to the perceived intensity of the stimulus in relation to the evoked sensations. McGuire (1995) stated that there are many available one-dimensional and multidimensional tools for pain management but not all dimensions are necessarily important to every patient with pain. These single dimension measures include: Numerical Rating Scale (NRS), whereby the subject is asked to rate pain numerically on the number range of either 0 to 5 or 0 to 10 scales. Verbal Rating Scale (VRS), in which subjects are asked to select from a small number of pain descriptors, most commonly presented as mild, moderate, distressing, severe, excruciating; Visual Analogue Scale (VAS), with or without verbal anchors, where subjects are asked to rate their pain on a 10cm line (Engen, 1971; McGuire, 1995). Multidimensional tools such as the Brief Pain Inventory and the McGill Pain

Questionnaire are also reported as being helpful in the assessment of cancer pain, provided the limitations of their validity are considered (Caraceni, 2001). Caraceni further explained that limitations exist as to the application of these scales to clinical situations such as type of pain, sensitivity to treatment effect and clinically significant pain and pain changes that are particularly relevant for management of cancer pain.

Harper and Bell (2006) outlines the development and implementation of a multi-dimensional pain assessment tool for use in acute hospitals. The authors argued that accurate and reliable communication skills are important in traditional methods of pain assessment. The authors further highlighted that patients who have limited communication skills, disadvantage or disability and other factors should be taken into consideration when assessing pain. These other factors include movement, vocalisation and facial expressions. The Harper and Bell pain assessment tool was developed to assist nursing staff address these factors and was compiled from research sources to incorporate the other factors for assessing pain.

Nurses have an important role in the use of pain assessment tools. Layman, Horton, and Davidhizar (2006), surveyed nurses' attitudes to the use of pain assessment tools in an acute care unit in a Midwest Community Hospital in the USA. Fifty two nurses completed the survey. Findings identified a surprising number and range of nurses' negative beliefs about the use of pain assessment tools. The researchers further pointed out that although the nurses were provided with the pain assessment tools considered by the relevant hospital to be sufficient, more than half of the nurse participants believed the tools were subjective and inaccurate. The nurses considered that the tools could be improved and were not necessarily a reliable measure of patients' pain. The study concluded that the level of patient pain

management satisfaction is greatly influenced by nurses and other professionals involved in that patient's care.

Brink-Huis (2008) reported on a review of the literature conducted to identify organisation models in cancer pain management that contain effective integrated care processes. The review involved a systematic search of the literature, published between 1986 and 2006. The findings of the review emphasized that evaluation of the quality of pain management should involve measurement of both patient and process outcomes. The author further concluded that outcome measures are major elements in monitoring the effects of pain treatment and the evaluation of care processes.

When considering the Sri Lankan situation regarding pain assessment, it is still in the beginning phase. Hiscock and Kadawatage (1999) undertook a descriptive comparative study of the attitudes of nurses and patients from two different countries. The authors studied thirty Sri Lankan and thirty English nurses' attitudes towards pain management with a self-administered questionnaire. The Sri Lankan nurses believed that they can determine the patient's pain through their knowledge and experiences without using any assessment tools. Seventy three per cent of Sri Lankan nurses thought that they always make an accurate assessment of the severity and intensity of a patient's pain situation whereas only 3% of UK nurses thought this. The authors further highlighted that pain is not assessed with the patients in Sri Lanka but on them, at the nurse's discretion.

United Kingdom and Sri Lankan researchers Williams, Chandler, Ranwala, De Silva, and Amarasinghe (2001), introduced pain tools for nurses in Sri Lanka through establishing the first Cancer Pain Clinic at the Cancer Hospital. The collaborative link project with a UK Cancer Pain Centre developed pain assessment and analgesic guidelines. The Brief Pain Inventory (BPI) was used to assess pain and the functional

effect of the pain with two questions: pain at worst and pain as it is now, in their survey of one hundred patients before and one week after Pain Clinic treatments. Results of the study identified an overall improvement in pain scores through utilization of the BPI. According to the authors, the introduction of the Pain Clinic was to provide a focus to help in the training of cancer pain management of health care workers such as doctors and nurses at the Cancer Hospital as well as implementation of pain assessment tools.

Assessment of cancer pain therefore remains a contentious issue with multiple pain tools available and a lack of a reliable approach to the task. Attitudinal beliefs and a lack of education also affect cancer pain assessment.

2.4 The cancer nursing role

Nurses who specialize in cancer nursing are considered pivotal to the success of collaborative patient-centered cancer care. This is because their role focuses on providing support to patients with cancer (Grundy, 2006). They also have the responsibility of improving the management of cancer pain in their patients. Pain is one of the nursing diagnoses that is most frequently identified as a clinical problem (Hallal, 1985). Nursing has responded to the increasing global awareness of inadequate cancer pain control by examining what nursing can contribute to this phenomenon.

Patient and family education has been identified in several surveys, as providing inadequate knowledge about how to manage pain (Lyne, Coyne, & Watson, 2002). This inadequate knowledge causes fear and stress for patients and their caregivers which may form a barrier to implementing care. Vallerand et al., (2004) had shown that increasing the education of caregivers leads to a reduction in barriers to cancer

pain management. Patient and family education on cancer pain management is a major aspect of the cancer nursing role.

An important role of the cancer nurses is that they act as case managers and take responsibility to coordinate care required including ongoing patient assessment and attending to patients needs (Ramamurthy, Rogers, & Alanmanou, 2006). Multiprofessional collaboration is proposed as the optimal process to meet the needs of cancer patients (Department of Health, 2000b). It is considered that through successful relationship building, nurses can implement the case manager role well (Willard & Luker, 2007).

Advocacy is also an integral part of nursing practice (Vaartio, Leino-Kilpi, Salanterä, & Suominen, 2006) and is based on respect for the person, and acknowledgement of human rights (Watt, 1997). According to the qualitative study by Vaartio et al., (2006) in Finland, where 22 adult patients experiencing procedural pain in somatic care and 21 nurses from four medical and four surgical wards were interviewed. The study findings highlighted that the quality of the nurse-patient relationship appears to be the basis for the advocacy role. The authors further pointed out that nursing advocacy integrate aspects of individuality and professionalism that result in empowering and exceptional care. An advocacy role is not a single event, but a process of analysing, counselling, responding, shielding and whistle-blowing activities in clinical nursing practice (Vaartio et al.).

Vallerand et al., (2007) suggested that the need to improve pain interventions for cancer patients should also be focused on the caregiver as the caregiver is often the person who administers pain medications. They further pointed out that communication skills, pain and symptom control and adjustment of opioid medication regimens are very important aspects in the role of the cancer nurse. Harper and Bell

(2006) also acknowledge the importance of nurse/ patient/ caregiver communication skills to assess and manage pain effectively.

Nurses have been described as the health care professionals most directly responsible for the overall management of cancer pain. Overall the cancer nursing role is complex with many aspects. The key to the nurse being able to function in the capacity of educator, coordinator of care and advocate is dependent upon an understanding of the factors which influence pain in cancer patients and knowledge of the most appropriate available intervention strategy.

2.5 Nurses' knowledge and attitudes about cancer pain management

There are many studies about nurses' knowledge and attitudes relating to pain management (Howell et al., 2000; Layman Young, Horton, & Davidhizar, 2006; Matthews & Malcolm, 2007; McMillan, Tittle, Hagan, Laughlin, & Tabler Jr, 2000; Rushton, Eggett, & Sutherland, 2003; Tafas et al., 2002; Vallerand et al., 2007; Young et al., 2006). According to these authors, there are multiple explanations regarding why poor cancer pain management occurs. These include a clear deficit in nurses' knowledge and attitudes in pain management related to inadequate education, inaccurate knowledge of cancer related pharmacology and poor cancer patient assessment skills.

Several explanations have been offered for nurses' inadequate knowledge and attitudes about pain management. The most common explanation is that nurses receive too little pain management education in their nursing curricula (Ferrel, Virani, Grant, Vallerand, & McCaffery, 2000; McCaffery & Ferrell, 1995; M. McCaffery, 2000; McMillan et al., 2000).

A survey of nurses' knowledge of cancer pain management in Australia, Canada, Japan, Spain and the United States identified that 25% or more of nurses in each country conveyed attitudes that cancer patients over report their pain (McCaffery & Ferrell, 1995). Survey results from all countries further highlighted a clear deficit in knowledge and attitudes in the field of cancer pain management. The authors strongly suggested the need to continually educate nurses about pain as they are the corner stone of cancer nursing.

A further study pointed out the importance of nursing education focused on pain management. McMillan et al., (2000) undertook an exploratory descriptive study at two large veterans administration hospitals in two adjacent counties in Florida to assess nurses' knowledge and attitudes about pain management with a convenience self-selected sample of 85 nurses. The findings of the study highlighted more pain management focus on education including physiology of pain, pharmacology is needed not only for the nursing students, but also for practicing nurses with the goal of therapy to a pain free state. The authors further stated that a lack of knowledge about pain management and poor attitudes may negatively affect pain management in patients with cancer. In addition, McMillan et al., emphasised the necessity of continued research to track potential changes in nurses' knowledge, attitudes and practices related to pain management.

Parallel with McMillan et al., (2000), Howell et al., (2000) investigated the effects of an educational intervention on nurses' knowledge, attitudes and practice in pain assessment and management over three months. The sample of 53 nurses for this descriptive, co- relational study was drawn from six inpatient units at a university-affiliated hospital in Canada. According to the findings of the study, most of the nurses believed that cancer pain can be controlled and patients should be pain free.

However, most nurses reported that more than 90% of patients had experience of pain longer than one month and most experienced discomfort before the next analgesic dose. The authors further highlighted significant differences in nurses' knowledge and attitudes immediately after the education intervention, but these were not maintained at the 3-month assessment. Basic and ongoing education about cancer pain management was therefore recommended by the study authors.

Though oncology nurses have more knowledge about cancer pain management than non-oncology nurses, it has been found to be not adequate to manage cancer pain. This was highlighted by a survey conducted by Rushton et al., (2003) to obtain information about the knowledge and attitudes of Utah nurses concerning cancer pain management. Forty-four oncology nurses and 303 non-oncology nurses completed the survey. Findings of this descriptive study were that oncology nurses had better knowledge of cancer pain management principles than non-oncology nurses. Rushton et al., further pointed out that all nurses' pain related pharmacology knowledge was not adequate. The study conclusion reported forty-three per cent of all nurses did not understand that non-steroidal anti-inflammatory drugs including aspirin were effective for bone pain related with cancer.

Bernardi, Catania, and Tridello (2007) undertook a nationwide survey of Italian hospice nurses' knowledge about pain management. The sample surveyed included hospice nurses working at hospices located in northern, central and southern Italy. Sixty-six nurses completed the questionnaire. The findings of the study pointed out that more than 30% of nurses underestimated patients' pain and they did not treat the pain in the correct way. Additionally nurses were found to incorrectly self-evaluate their knowledge of pain management. Results from stepwise regression highlighted that nurses with a higher mean correct answer scores had participated in more courses

on pain education. According to these results, the authors concluded that there are still significant knowledge deficits and erroneous beliefs that hamper treatment of patients in pain.

A comparative study examined two different cultures: Sri Lanka and United Kingdom (UK) on the attitudes of 30 nurses and 30 patients towards pain (Hiscock & Kadawatage, 1999). The study found nurses' attitudes to pain are very different within developing and developed countries. This study highlighted 50% of Sri Lankan nurses believed that patients use symptom of pain to obtain more benefits or preferences; do not hurt as much as they say they do and may not have pain at all. Whereas only 3% of UK nurses believed this. The authors pointed out the judgemental attitude of not trusting patients when they report their pain and thinking that the nurses can make an accurate assessment may result in patients not receiving appropriate treatment. The authors recommended that more education on pain management for nurses in Sri Lanka is required.

The problem of nursing education in Sri Lanka was further highlighted by Williams et al., (2001), who establishing a cancer pain clinic in Sri Lanka. According to their assessment of 100 nurses' attitudes towards effective cancer pain control, more than half of the nurse participants' knowledge and attitudes were very poor about cancer pain management. Nurse participants felt that medical officers were also less knowledgeable about the concept of cancer pain management. The researchers recommended in their study the need to develop education programs for medical and nursing staff. Most of the studies that relate to nurses' views of pain management strongly highlighted the need for basic and continuous education in pain management not only in developing countries but also in developed countries (Bernardi et al., 2007; McMillan et al., 2000; Rushton et al., 2003; Williams et al., 2001).

Overall it can be concluded that nurses' knowledge and attitudes to pain management requires further research in developed and developing countries. Evidence currently available highlights that many patients receive poor cancer pain management because of nurses' attitudes and inadequate nurse education.

2.6 Barriers in cancer pain management

Significant improvement in cancer pain using the World Health Organization (WHO) Analgesic Ladder and the interventions offered can occur. Nevertheless, for a significant number of patients, there are reports that document high levels of inadequate pain control (Wells, 2000). Previous studies pointed out the various barriers to pain management among nurses (Vallerand et al., 2007; Vallerand et al., 2004; Williams et al., 2001). According to them, a lack of knowledge, inadequate assessment skills, the likelihood of addiction concerns, opioid-induced respiratory depression and concerns about side effects and communication with physicians and the nurse-physician relationship are major barriers, as well as misconceptions about cancer pain.

Several studies have been conducted with oncology nurses and physicians in an attempt to identify why cancer pain remains inadequately managed when sufficient treatment is available. The Eastern Cooperative Oncology Group (ECOG) surveyed almost 900 physicians and asked them to rank, in order of priority, barriers that they identified in their practice as impeding pain management. The physicians believed inadequate knowledge of cancer pain assessment is the main barrier. Additionally, management and barriers were related to the patient and family are prevalent with the patient being reluctant to report pain and take opioids (Von, Cleeland, Gronin, Hatfield, & Pandya, 1993).

The need for patient and family education is based on several surveys, which have shown that patients and their families have inadequate knowledge about how to manage pain. This inadequate knowledge causes fear and stress for patients and their caregivers which could be a barrier to implementing care. In an attempt to examine more specifically how family factors influence pain management, Ferrell et al., (1991) interviewed 85 patients with cancer pain from three sites of care: a hospice, a community hospital and a cancer centre in California. The aim of the study was to examine the social concerns associated with cancer pain management. The authors were particularly interested in how the knowledge base of the carer impacted on someone in pain. Though the study was not designed to measure the impact of caregivers' knowledge on pain management, the results showed that the greater the understanding the carer had of pain management principles, the less stress carers' experienced in managing their family member's pain. The reduction in carer stress levels was reflected in lower levels of depression and less confusion about pain management regimes. Again, the study concluded that there was an urgent need to address this barrier and educate families in effective cancer pain management strategies.

The World Health Organization (WHO) and other authorities consider that there are three main barriers to effective cancer pain control in developing countries, such as government policy, education of health care members and availability of cancer relieving drugs (mainly opioids) (Joranson, 1993; Stjernsward, 1988; World Health Organization, 1990). Government policy and related law in Sri Lanka permits the adequate use of analgesics for cancer patients but pain management education and opioid availability are low in practice (Williams et al., 2001). This problem was highlighted by Williams et al., who surveyed 100 nurses in Sri Lanka about attitudes

towards effective cancer pain control. Almost half of nurses agreed that 'opioid doses could not be repeated more than 3-4 hourly because the patient may develop dependence', whilst 42% of nurses believed that medical officers were reluctant to prescribe analgesics. Additionally, almost half of the nurses were afraid of side effects such as respiratory depression and one third of the nurses stated that it was difficult to get relevant analgesics due to difficulties with the supply of the drugs.

A pre-test post-test study with a survey was conducted by Tafas et al., (2002) to test the construct validity, test-retest reliability and internal consistency of Greek nurses' knowledge and attitudes survey regarding pain. Forty-six registered nurses were randomly assigned to an expert or non-expert group. Nurses in the expert group viewed a Greek translated version of four pain management videotapes by Margo McCaffery. Nurses in the non-expert control group did not view the pain management videotapes. Expert nurses were compared with non-expert nurses during the post-test. A sample of 58 Greek registered nurses completed the pre-test, with 46 of these nurses completing the post-test. According to authors, both groups of nurses surveyed demonstrated a lack of knowledge and myths and misconceptions about pain similar to reports in the general and oncology nursing literature. The lowest percentage of correct responses in the post-test for both groups related to questions about the duration of action of intramuscular meperidine, proper route of administration for patients with prolonged cancer pain and the helpfulness of non-drug pain interventions for severe pain (6.5%, 8.7%, and 21.7% respectively). The low score suggests that more emphasis must be placed on educating nurses concerning these pain management content areas. The highest percentage of correct post-test scores for both groups related to titrating opioids based on patient response and cultural influences on pain. These were 87% correct for both questions. The ultimate aim of

this study is to significantly reduce the pain experienced by patients with cancer in Greece thereby relieving suffering and improving quality of life.

A recent survey was conducted by Yu and Petrini (2007) to explore Chinese nurses' current knowledge of pain in older people. Six hundred and twenty one registered nurses in three different hospitals in China were surveyed about pain and pain management with respect to older people. The authors of this study pointed out that nurses' poor knowledge and misconceptions concerning the use of analgesics and addiction was revealed. Additionally Ferrell, McGuire, and Donovan (1993) have stated that a lack of knowledge on the part of nurses about pharmacological management is one of the major barriers to achieving comfort for those in pain.

It is reported that most developing countries face common problems with pain management from a lack of resources, inadequate education and drug availability (Beck, 2000; Williams et al., 2001). Further, additional factors can be considered: widespread ignorance about WHO guidelines, myths about the use of morphine even though it is available in developing countries, inadequate support services and facilities for palliative care. As well as not enough hospices and underdeveloped social welfare services (Vijayan, Esser, & Steigerwald, 2003).

As Sri Lanka is a developing country with a large population of over 21 million persons, cancer treatment facilities are not adequate with only one specialized cancer hospital in the country. Williams et al., (2001) and Hiscock and Kadawatage (1999) also pointed out pain control facilities in Sri Lanka were relatively underdeveloped, with no formal methods to assess acute or chronic pain and limited use of cancer pain relief drugs.

Barriers to adequate pain management still exist, including those related to health-care professionals, the health-care system and patients. The most common barriers to

pain management include knowledge deficits, misconceptions about opioids and their side effects, inadequate assessment and organizational issues that directly influence effective cancer pain management more so in developing countries than developed countries.

2.7 Cultural influences in cancer pain management

Cultural influences have been found to influence cancer pain management. Determining how pain is perceived, how and whether an individual communicates their pain or makes their pain public and how the person acts or responds to the pain experience is required (Helman, 2000). Helman stated that pain is private and to know whether a person is experiencing pain, it must become public through verbal or nonverbal communication, signals or behaviours. Social, cultural, as well as psychological factors will determine whether private pain is expressed as pain behaviour, the form of this behaviour, the social setting or culture where it will occur and the response of others to the person's pain experience (Lovering, 2006).

Psychological and cultural differences are referred to in the literature as influencing cancer pain management. The WHO (1990) model and recommendation is that developing countries establish a threefold strategy of: government policy; education and drug availability for achieving cancer pain relief. A criticism of the model is that it does not address the various psychological and cultural beliefs which influence expectations about cancer pain in a given country (Beck, 2000).

Lovering (2006) conducted a collaborative inquiry project using a culturally diverse group to increase cultural understanding and knowledge in Saudi Arabia. The findings of the study revealed that nurses and other health professionals attributed the causes of pain to nonmedical causes such as the evil eye, divine intervention and other

supernatural causes. The author pointed out that this supports the view that personal and cultural views will exist alongside medical explanations of pain. According to the author's findings, the use of traditional, spiritual and religious healing methods for pain treatment is also consistent with the view that personal or cultural values can dominate the pain experience.

Several factors have been reported in the literature to influence how an individual presents their pain such as personality, previous experiences, anxiety and culture (Hiscock & Kadawatage, 1999). Beck (2000) undertook an ethnographic study in South Africa to explore cultural and other factors influencing cancer pain management. The author concluded that individual's cultural differences influence the experiences and management of cancer pain. Lack of knowledge and attitudes, inadequate resources, issues of communication such as language barriers, mistrust and nonprofessional attitudes were identified by the author as influencing how a person experiences pain.

It is reported in the literature that Chinese patients are reluctant to report pain as they want to maintain the social norm of 'good' patient. In addition Chinese culture places more emphasis on harmony (Wills & Wootton, 1999). However Wills and Wootton further highlighted the importance of health care professionals to care for each patient as an individual and that they should avoid stereotyping along ethnic lines.

Hiscock and Kadawatage (1999) compared attitudes toward pain management between 30 nurses and 30 patients from the United Kingdom and Sri Lanka. Significant differences in nurses' beliefs about assessing and managing patient's pain existed between the two cultures. According to the authors' comparative study 76% of Sri Lankan nurses thought some ethnic groups tolerate more pain than others, whereas

only 50% of UK nurses believed this. Thirty-three per cent Sri Lankan nurses were unsure as to whether all the pain had an identifiable physical cause but only 16% of English nurses were unsure. The authors attributed these differences to a lack of pain assessment knowledge and education for nurses in Sri Lanka as well as cultural beliefs about pain. Assessments of individual patients therefore are necessary because individuals have their own cultural perceptions. The authors also pointed out the need for better understanding about cultural attitudes, values and beliefs of patients as individuals before attempting to manage their pain.

Scott et al., (2008) investigated the geographic and cultural factor that influences quality of life for cancer patients. Seven subscales representing fatigue, pain, physical, role, emotional, cognitive, and social functioning were used in the study. The researchers accessed a large international database of over 39,000 individuals globally. Sri Lankan data were included in the study in a South Asian Group. The researchers considered that the study results reflect on how people from different cultural groups interpret quality of life. There was evidence in the study results on a greater emphasis on cognitive functioning from South Asia people compared with the UK concerning quality of life.

The concept of pain has been studied from a cultural perspective, however much of the research is focused on minority group behaviour in the context of western culture or the western health care system. There has been little research conducted on cultural attitudes toward pain within a non-western health system. There were also no other studies whose purpose was to obtain information concerning views of cancer pain management among nurses in Sri Lankan settings. Lasch (2000) pointed out that research studies on pain management within a cultural context are underdeveloped

and weak from a methodological standpoint, with a failure to distinguish between ethnicity, culture and race.

2.8 Cancer pain management in developed countries

Cancer and cancer pain is a worldwide problem. Therefore its features have been surveyed extensively (Martin, 1998). Goudas, Bloch, Gialeli-Goudas, Lan and Carr (2005) undertook a literature search to present an overview of existing evidence on the occurrence and epidemiological characteristics of cancer related pain. The authors identified 28 surveys from 464 studies by a thorough comprehensive systematic review applying a sensitive search in Medline and CancerLit databases, supplemented by hand searches including two surveys that had enrolled more than 10,000 patients with cancer. Fourteen surveys were conducted in the United States and the majority of the remaining studies were conducted in Europe (Finland, France, Germany and UK/Ireland). According to the authors, no single survey identified a prevalence of any type of pain below 14%. The prevalence of pain reported in these surveys varies with the specific type of pain (e.g. breakthrough pain) and/or population studied. However, the findings of this review suggested that a significant number of patients with cancer worldwide will, during the course of their disease, experience pain.

As much as people in developed countries experience cancer pain, the problem is greater in the developing countries. The World Health Organization has documented the widespread prevalence of inadequate cancer pain relief around the world in developed and developing countries. The prevalence and multidimensional nature of cancer pain has achieved a lot of attention from the WHO and from other professional agencies over the last few decades. These organisations examined the efficacy of several treatment modalities for cancer pain relief (Agency for Health Care Policy and

Research (AHCP&R), 1994; World Health Organization, 1986). Cancer pain relief was recognized by the WHO as a health priority almost twenty years ago. An analgesic ladder was developed which has been shown to be effective in relieving pain in approximately 90% of patients with cancer and over 75% of cancer patients who are terminally ill (World Health Organization, 1990).

Many large health care professional agencies identified the nurse as the health care professional who should assume a leadership role in overcoming the many barriers that currently impede effective cancer pain management. The American National Institute of Health integrated approach to cancer pain management describes the role of the nurse as being pivotal in improving cancer pain management (National Institute of Health Consensus Development Conference, 1987). Some studies have examined strategies to develop pain relief and have recommended that nurses take a more prominent role in cancer pain management (Ferrell et al., 1991; Ferrell, Jacox, Miaskowski, Paice, & Hester, 1994). The responsibility of the nurse in pain management stems from the primary care giving role of the nurse and the fact that the nurse is the health care provider with the most patient contact in hospital settings. In addition, the broad range of analgesic regimens prescribed by physicians implies that nurses decide how to adjust both the amount and frequency of the dosage necessary to provide adequate pain relief. Nurses not only administer pain-relieving medication but are also in the best position to evaluate the effectiveness of the intervention (Slack & Faut-Callahan, 1991).

The American Nurses Association (ANA) / Oncology Nursing Society (ONS) have both defined the role of the nurse in cancer pain management as being that of an educator, coordinator of care and an advocate (American Nursing Association/Oncology Nursing Society, 1987). It was the mission of the Oncology

Nursing Society to promote improvement in the quality of nursing care of patient with cancer. A comprehensive guide for improving nursing care was described in the ONS Position Paper (1987). The specific objective was to draw attention to the problem of unrelieved cancer pain and to define the responsibilities of professional nurses in relation to cancer pain management. The ONS Position Paper operationalised the scope of practice for nurses by defining the knowledge and skills that would be required if nurses were to assume their ethical as well as clinical responsibilities. The ONS believed that nurses with such knowledge would be able to assess pain in patients with cancer, develop and implement a care plan for the management of the pain and be able to evaluate its therapeutic efficacy (Spross, McGuire, & Schmitt, 1990a).

The World Health Organisation and other professional organisations in the developed world have already identified the importance of cancer pain management over the last decades. However, cancer pain management is still a worldwide problem due to various reasons such as a lack of knowledge, skills and poor attitudes among health care workers including nurses.

2.9 Cancer pain management in developing countries including Sri Lanka

Little is known about the prevalence of cancer pain in many developing countries including Sri Lanka as minimal literature has been published on the phenomena. An Indian case study by Koshy, Rhodes, Devi, and Grossman (1998), highlighted that novel approaches which address fundamental concerns about opioid availability in developing countries are desperately needed. One such approach, which is currently under development, is that of a polymer opioid delivery device implanted under

patients' skin. Koshy et al., believe this approach will not address all the drugs administration issues in India. However, it does present an alternative approach which government officials and practitioners may find attractive. This has the potential to make opioids available to patients in rural areas, develop compliance in the poorly educated patient, decrease the number of follow-up visits necessary for medication refills and reduce the risk that opioids will be diverted to illicit channels. The potential for managing cancer pain and the importance of this problem worldwide make it imperative that innovative approaches be tailored to the complex social issues and limited resources common to developing countries. The authors further pointed out cancer pain are often undertreated even in developed countries with abundant resources and easy access to oral, parenteral and transdermal opioids.

Size, Soyannwo, and Justins (2007) believe that effective pain management is unavailable to large number of patients in developing countries because a low priority to analgesia over other aspects of health care given. As an example, India produces approximately 80% of the world's medicinal opium. However, morphine distribution to patients in India is poor because of concerns with illegal distribution activities. Davis & Walsh (2004) also described that India uses the same amount of morphine as Denmark which has 900 million fewer people. It is not surprising, therefore, that Sri Lanka follows the trend of India and has one of the lowest morphine consumption levels in the world, less than 20 daily defined doses per million population, compared with 2000 plus in the United Kingdom (Williams et al., 2001).

Reyes-Gibby et al., (2006) conducted a recent hospital-wide pain survey in a tertiary cancer centre in Hanoi, Vietnam. One hundred and seventy-eight inpatients and outpatients aged 18 years or older participated in the study. Data were collected using the Brief Pain Inventory. Prevalence of moderate to severe pain was 50%

(89/178), with 23% of participants reporting pain at its worst and 33% reporting severe impairment in their ability to work due to pain. Only 1% of patients reported total and 40% partial pain relief from medications. This study is among the first to provide a representative view of pain in a tertiary cancer treatment centre in Vietnam. The findings highlighted the importance of research for better programmable efforts to improve the relief from cancer pain for patients in developing countries.

When considering the population and geography of developing countries, part of the problem is in delivering health care to rural populations served by poor road network with non-existent public transport (Size et al., 2007). Size et al., acknowledge that better facilities may exist in the main cities but these maybe costly and unaffordable for the majority of the population who live in rural areas. Government sponsored Sri Lankan health services are free and are delivered through an extensive network of health centres, hospitals and dispensaries; from primary to tertiary level, reaching the majority of the community (Department of Health Services-Sri Lanka, 2003). According to Department of Health Services, on average, the public can freely access a health-care unit no further than 1.4 km from any home while the Allopathic type of health-care services are available within 4.8 km of patients' homes. There are some cancer treatment units attached to the general hospitals but the main cancer treatment facilities are centred in the Cancer Hospital, Maharagama, a suburb of the capital city Colombo (Williams et al., 2001).

As Sri Lanka is a developing country the lack of finances is a significant barrier to improving not only health care facilities infrastructure and resources, but also to better management of cancer (Martin, 1998; Size et al., 2007). According to Size et al., health care facilities are often under staffed, with staff receiving comparatively little training in pain management. Size et al stated that "it is not uncommon to have two

nursing staff looking after a ward of 50 patients” (p. 39) in a rural hospital in sub-Saharan Africa. Many developing countries have a similar situation.

Current healthcare services in Sri Lanka are also understaffed and mainly focused on curative measures rather than preventive measures (Jayasekara & Schultz, 2007). According to Withanachchi and Uchida (2006), 22% of nurses, 10% of public health midwives, 28% of public health inspectors and 44% of public health nursing sisters positions were vacant in 1999. However, there have been significant increases in the number of categories of manpower in the public sector. The government is absorbing all the medical graduates passing out from the medical faculties. There were six doctors per 10,000 populations in 2006 and 14 nurses per 10,000 populations in 2006 (World Health Organization, 2008).

Throughout the last 50 years, the total public expenditure on health care settings in Sri Lanka averaged below 2% of gross domestic product (GDP), which is very low rate by international comparisons as the WHO recommendation of 5% (Abeykoon, 2003). Jayasekara and Schultz (2007) provides a comprehensive review of current health service administration, health status, trends and issues, and health financing and resource allocation in Sri Lanka. The authors revealed that Sri Lanka has achieved a relatively high health status given a low level of spending on its health care services when compared with other developing countries. McElmurry et al., (2006) also pointed out that Sri Lanka has achieved better health outcomes than have richer countries such as South Africa because of government support for health, education and other social programs. However, Sri Lanka still experiences vital health problems mainly related to lifestyle and the transition associated with widespread societal and economic crises such as 19 years civil war and 2004 tsunami (Jayasekara & McCutcheon, 2006; Jayasekara & Schultz, 2007).

Lack of training about cancer pain management is a major factor affecting care of patients with cancer pain in developing countries (Koshy et al., 1998; Size et al., 2007; Williams et al., 2001). Koshy et al., pointed out that pain assessment and pain management is not formally taught even in Indian medical schools. Physicians are often concerned with potential toxicities, addiction and other side effects which lead to delayed initiation or inadequate utilisation of opioid therapy. A culture of medical non-intervention has evolved from lack of acknowledgement of therapeutic cancer pain management strategies. This approach impacts on patients who think nothing can be done for their pain and they suffer in silence (Size et al., 2007).

Relieving cancer pain and the enormosity of this problem worldwide make it imperative that innovative approaches be tailored to the complex social issues and limited resources common to the health related sectors in developing countries including Sri Lanka.

2.10 Nursing in Sri Lanka

Nursing in Sri Lanka is still at the evolving stage when compared with other developing and developed countries. There is no specialized field of Oncology Nursing in Sri Lanka.

A study of nurses' and patients' practices towards pain from two different cultures, Sri Lanka and United Kingdom(UK), identified that Sri Lankan nurses perform task oriented nursing, whereas in the United Kingdom (UK) nurses used primary nursing and team nursing approaches to caring for patients (Hiscock & Kadawatage, 1999). According to the authors, the ratio of patients to nurses in Sri Lanka is 4 per 60-70 patients in the general ward, whereas in the UK it was 1 per 7 patients. Consequently task oriented nursing is all the Sri Lankan nurse is able to perform with such a

workload. Due to this situation of nurses availability, it is often difficult to manage cancer pain effectively. Williams et al., (2001) also stated that it is not uncommon to have as few as one nurse to twenty patients in Sri Lanka. Hiscock and Kadawatage further pointed out that in Sri Lanka, relatives are involved as bystanders in feeding, washing and general care of patients while the nurse engages in tasks such as administering medicines. Whilst in the UK, nurses perform all nursing care. Furthermore, the authors highlighted how no education was given to patients in the form of booklets, videos and health talks about what effect surgery may have. Whilst in the UK, patients are prepared for the postoperative period and potential pain conditions in various ways through pre-admission clinics, videos and booklets.

The shortage of nurses in Sri Lanka was also highlighted by Perera, Amarasinghe, and Wijesundara (2004) in their collaboration project with, Royal Marsden Hospital, UK. The establishment of a Breast Cancer Clinic in the Cancer Hospital, Maharagama, Sri Lanka warranted a permanent Breast Nurse. However, it is hospital policy to transfer nurses between clinics and wards due to the existing acute shortage of trained, specialized nurses. This post of Breast Nurse was not established to the detriment of competent breast cancer nursing practice.

Jayasekara and McCutcheon (2006) explored the evolution of nursing services and education in Sri Lanka and the effects on developing professionalism in nursing. The authors searched internet databases, spoke to relevant persons and reviewed published and unpublished literature and reports to obtain historical information on nursing services and education in Sri Lanka. According to the authors, nurses are a crucial part of the workforce. However, there has been minimal effort to improve the standards of nursing education, primarily due to inadequate involvement of those

responsible for improving health services in Sri Lanka namely, Ministry of Health and the government.

Overall, Sri Lankan nursing needs to develop within international standards and include specializations in different fields such as oncology nursing. It also needs to strengthen qualified nurses' knowledge and attitudes to cancer pain management.

2.11 Traditional health behaviors in Sri Lanka

Sri Lanka has many traditional health behaviours. According to the Sri Lankan cultural and traditional beliefs, alternative modes of treatment such as aurveda (native treatments), homeopathy, acupuncture and spiritual healing methods either alone or in combination are used by a large number of people (Seneviratne, Rajapakse, Pathirana, & Seetha, 2002). A study of 207 epilepsy patients in rural Sri Lanka identified that the majority have tried religious and spiritual healing methods to cure their diseases (Seneviratne et al., 2002).

Pieris (1999) undertook two studies to review, the evolution of Sri Lanka's health care system from the traditional to the modern. Those studies involved a combination of structured interviews and unstructured in-depth interviews with family members. They also included special interviews with older women on changes of health behaviour and the different health rituals practised in Sri Lanka. According to Pieris, when people think the course of the disease is seen as supernatural, it is treated by ritual or magico-religious types of cures. The author highlighted the different traditional practices for such illness such as:

exorcism, yantra, mantra, charmed string, oil or water, cutting limes, bodhi puja (offering at a Buddhist temple), making vows promising to give alms, objects or even money, services by a priest, visiting palm readers or horoscope readers, and burning spice mixtures (Pieris, 1999, p. 40).

The author further explained some rituals involving charmed water, oil and string generally performed by a Buddhist monk or a *Kattadiya* (priest who performs rituals), and the patients has to drink this charmed water and the oil is applied to the body to relieve pain and provide rapid recovery of the disease. Placing charmed threads or *Yantra* and written *mantra* on chromium plates and putting them in a cylinder shape pendent to wear around the neck occurs. Making vows to God or gods and promising offerings to Lord Buddha are also practised. This occurs even if people are engaging in other traditional or western medical treatments.

According to Pieris (1999), it is hard to separate supernatural healing from traditional people in Sri Lanka. Western and supernatural health systems are used simultaneously until it is recognized whether or not the treatment achieves result, namely a return to good health and well being. However, most of the Sri Lankan population believe they can get some kind of relief from religious activities parallel to their treatment with western medicine.

2.12 Summary of literature

This literature review highlighted how nurses are health care professionals involved in the assessment and management of cancer pain in patients. The National Institute of Health, the American Nurses Association and The World Health Organisation have all defined the role of the nurse in cancer pain management as being that of an educator, coordinator of care and an advocate.

This review highlighted that patients with cancer pain are still suffering from severe pain even though adequate treatments are available. Unrelieved pain in patients with cancer is an international health problem. The importance of increasing the knowledge and attitudes regarding cancer pain management of caregivers and nurses

is paramount. Most of the studies pointed out nurses' clear deficits in knowledge and attitudes about cancer pain. The deficits in this area of practice are often attributed to inadequate education, inaccurate knowledge of pharmacology of analgesics, poor pain assessment, education and guidelines for practice.

CHAPTER 3

METHODOLOGY

3.1 Introduction

This chapter describes the methodology and research design of the study. Specifically, the researcher outlines the rationale for selecting qualitative research as the methodology for the study in this chapter. The research method of ethnography will be discussed along with the data collection strategies of participant observation; field notes and semi-structured interviews. The aim of this study was to explore the nurses' cancer pain management practices in Sri Lanka. The objectives for this study are to:

1. explore the cancer pain knowledge and attitudes among nurses in Sri Lanka;
2. identify nurse cancer pain management practices;
3. identify the barriers to nurse cancer pain management;
4. identify therapeutic and non-therapeutic cultural pain management therapies used by cancer patients in Sri Lanka.

3.2 Nursing research

Research is a systematic way of thinking and knowing and includes any type of investigation for the purpose of revealing knowledge. In simple terms as described by Neuman (2006), it is a way of going about finding answers to questions. It is a purposeful activity and is conducted for a specific reason to answer a particular question or solve a specific issue (Depoy & Gitlin, 2005). Though the research may seem unimportant, it has relevance for daily life activities (Neuman, 2006). Educators,

parents, business managers, leaders, administrators, government officials, human service providers and health care professionals including nurses regularly use research findings and new knowledge in their discipline (Neuman).

As a result of the significant developments in the field of health in all parts of the world, improved health outcomes as well as raised public expectations of health care services has occurred. It is therefore necessary for nurses to have knowledge and skills to provide high quality care to individuals and communities with whom they work. To develop such knowledge, nursing research is of paramount importance to the nursing profession (Gerrish & Lacey, 2006). Due to broad support for evidence-based nursing practice, nursing research has increased (Polit & Beck, 2008).

Nursing research is a systematic inquiry which helps to develop knowledge regarding issues of importance to nurses (Polit & Beck, 2008). Though nursing research began with Florence Nightingale, it developed very slowly until its rapid development around 1950s. After 1970, nursing research became focused on problems relating to clinical settings (Polit & Beck). Nursing research has experienced remarkable growth in the past three decades, providing sound evidence-based practice knowledge for nurses (Polit & Beck).

Currently, the majority of nursing research has occurred in developed countries. Nurses in developed countries have been able to undertake research because they have the resources and education do so. Sri Lankan nurses are yet to be aware of evidence-based nursing care. This study will be a small step in the pursuit of developing a research culture in Sri Lanka. The study: an exploration of nurses' cancer pain management in Sri Lanka will help enrich nurses' knowledge regarding cancer pain management and its importance to the profession. Further, undertaking this research

will help to discover new knowledge and gain a richer understanding of the care of cancer patients in developing countries (Neuman, 2006).

3.3 Qualitative (naturalistic) and quantitative (experimental-type) research

There are two primary philosophical traditions in research that can be categorised as representing both qualitative research (naturalistic inquiry) and quantitative research (experimental-type). Both research traditions have strengths as well as limitations because both have value in investigating the depth and breadth of research topics (Depoy & Gitlin, 2005). Qualitative research is based on multiple philosophical traditions that can be categorised as holistic as it is believed human experience is complex and cannot be understood by reductionism, therefore it focuses on an inductive form of human reasoning (Depoy & Gitlin). A characteristic of naturalistic design is flexibility with the procedures and plans for conducting this type of research, changing as the study progresses. In quantitative research, however, a blueprint for action or a predetermined structure to the data collection and analysis is determined early in the research process (Polit & Beck, 2008). Though qualitative and quantitative research have many differences in many ways, they complement each other because the researchers systematically collect and analyse empirical data to understand and describe social life (Neuman, 2006). One of the main differences between these two research approaches comes from the nature of the data (Neuman).

Quantitative approaches are based on positivism whilst qualitative research has an interpretive focus. Quantitative research seeks causal relationships between variables, things that can be sensibly assigned numbers in social settings. It seeks to analyse and understand the nature of these causal relationships (Denzin & Lincoln, 2005). The

research aims, depends on explanation of prediction and control rather than understanding. However, a critique of when quantitative methods are relied upon, is they may neglect social and cultural construction of the variables that quantitative research seeks to correlate (Silverman, 2006). One advantage of quantitative research is that large amounts of data can be gathered within a short duration. Overall, quantitative research is objective, has a belief in one reality, is measurable, mechanistic, with parts equalling the whole and the researcher is separate or independent to the research process (Speziale & Carpenter, 2007). Quantitative research has some value in nursing research; however, for this study a qualitative approach was used.

In contrast to quantitative methods, qualitative research methods are qualified in words in form of impressions, sentences, photos, symbols and use a variety of approaches instead of quantity or numbers (Neuman, 2006; Silverman, 2006). Holloway and Wheeler (2002) define qualitative research as a form of social inquiry which focuses on the way people interpret and make sense of their experiences and the world in which they live. The tradition of qualitative research was derived from social sciences with research methods using an interpretivist perspective, emphasising meaning and the understanding of human actions and behaviour (Gerrish & Lacey, 2006).

Qualitative research structure is exploratory, providing new insights, meaning and description as it seeks to illustrate, understand and interpret or explain about the day-to-day life experiences and structures from the perspective of those studied. Qualitative research is not only a situated activity that locates the observer in the world, but also involves an interpretive, naturalistic approach to the world to make sense of, or interpret phenomena in terms of the meaning people bring to their natural

setting (Denzin & Lincoln, 2005). This can be achieved by being in the field and interacting with a small group, not by inferences from what is conducted in artificial settings like experiments (Hammersley, 1990). Overall, qualitative researchers aim to cover all aspects of the social setting they choose to study and try to explain how the different parts fit together.

In qualitative research studies with small samples, subjectivity has come under criticism in that the findings are of little value because they cannot be generalised. Hammersley (1990) reported on studies with small samples and stated that “the concern is not with empirical generalisation, but rather with making theoretical inferences and this does not require the case studied to be representative” (p.10).

Hammersley further pointed out that researchers use methods designed to establish that their findings are not idiosyncratic. This occurs by comparing data from different perspectives through varied data collection methods.

In the conduct of research, certain attributes are common to the discovery process of both qualitative and quantitative research approaches (Speziale & Carpenter, 2007). Neuman (2006) considers the best way to appreciate the strengths and weaknesses of each style are on its own terms rather than by judging qualitative research by standards of quantitative research, and vice versa. Therefore the selection of research design is based on its suitability for exploring the research area that interests the researcher and is appropriate for the study.

3.4 Rationale for selecting methodology

The methodology selected for the study is based on the research questions. Maxwell asserts that to explore a research question, the researcher needs a method

that enables understanding of the meaning for participants in the study, of the event, situations, experiences and their actions in the field (2005).

Qualitative research consists of a number of methodologies that have been used frequently in health and nursing research. Since the aim of this research is to explore nurses' experiences and practices in cancer pain management, a qualitative research approach rather than quantitative research method has been selected to explore the meaning, actions and interpretations of nurses' cancer pain management practices in Sri Lanka. As a novice researcher, the qualitative approach is appropriate for the research aim of exploring in-depth understanding of cancer pain management in a Sri Lankan clinical setting rather than numeric value. Instead of looking at a limited number of predetermined variables as survey researchers have to do, qualitative field researchers derive deeper understanding from the large, complicated, multifaceted, social and historical contexts within which people's lives unfold (Bailey, 2007).

As Sri Lanka is a developing country with limited resources and specific cultural groups, an ethnographic study is appropriate to explore the cancer pain management practices of nurses. Liamputtong and Ezzy highlight how "ethnography is distinct as a qualitative approach in that it attempts to interpret and present its findings from a cultural perspective" (2005, p. 17). For this study, the cultural perspective is the workplace of Sri Lankan nurses caring for cancer patients.

3.5 Ethnography: Methodology for the study

Ethnography is the most suitable qualitative research method to investigate the aims and objectives of this study. It was selected because it offers both researcher and participant perspectives of what is done and what it means (Leininger, 1985). Every human behaviour has meaning and ethnography research enables discovery of the

meaning of the behaviour (Speziale & Carpenter, 2007). Literally, the word of ‘ethnography’ means “to write about people or cultures, from the Greek Words *ethnos* (people) and *graphei* (to write)” (Marvasti, 2004, p. 36). Ethnography is the work of describing a culture. A description of ethnography that relates to this study has been provided by Spradley:

Ethnography is a culture-studying culture. It consists of a body of knowledge that includes research techniques, ethnographic theory and hundreds of cultural descriptions. It seeks to build a systematic understanding of all human cultures from the perspectives of those who have learned them (Spradley, 1979, p. 9).

Fetterman (1998, p. 1) defines ethnography as “the science or art of describing a group or culture”, as it helps to raise questions about social organization, cultural rules and regulations. According to this definition, ethnography provides a means to understand another way of life from another person’s point of view (Spradley, 1979). Spradley (1980) also pointed out that “the essential core of ethnography is concerned with the meaning of actions and events to the people (ethnographers) seek to understand” (p.5). However, Spradley further described how ethnography is more than the study of people as it is also learning from people. In ethnography research the researcher can behave as the research instrument identifying, interpreting and analysing the culture under study (Speziale & Carpenter, 2007). Therefore ethnography is a valuable research approach in understanding the culture of specific groups including nurses and is the appropriate method for this study.

Ethnography originated as a method in cultural anthropology (Denzin & Lincoln, 2000; Hammersley & Atkinson, 1995; Marvasti, 2004). Its early beginnings were in social anthropology in the late nineteenth and twentieth century when famous anthropologists such as Malinowski (1922), Boas (1928) and Mead (1928), explored several non-western cultures and the lifestyles of the people within them. The authors

reported the first development of the research method was the emergence of the classical tradition of social anthropology in Britain attributed to Malinowski. The second development has been the work of the Chicago School in Sociology which used observational methods in America from 1910 to 1930 (Brewer, 2000; Neuman, 2006). From 1940 to 1960, the Chicago School gradually developed participant observation as a distinct technique and expanded it as an anthropological model to groups and settings (Neuman, 2006). Finally self confidence about techniques and methods to observe and interact with members in natural settings to obtain an inside perspective occurred (Neuman, 2006). According to Brewer (2000) ethnography evolved further and has now moved to other areas of social sciences such as education and health studies where it is considered a valuable research method.

Liamputtong and Ezzy reported that in the last two decades, there have been an increasing number of health focused research studies utilising ethnography as a method (2005). Other authors confirmed this statement with ethnography becoming a popular method in health related research, along with other types of qualitative methods in recent decades (Hammersley & Atkinson, 1995; Marvasti, 2004). This is partly the result of dissatisfaction with the information collected by quantitative methods because quantitative methods are considered to not give the complete picture of the health related behaviours that researchers hope to understand (Marvasti, 2004). The value of ethnography studies are that they provide the whole story and in depth understanding about people's health related behaviours and help to identify solutions to improve health and well being (Liamputtong & Ezzy, 2005).

Ethnography research methods can be utilised to describe nursing practices in different countries and clinical settings (Leininger, 1985). Ethnography is particularly appropriate to study health beliefs, attitudes, practices and patterns in a social and

cultural settings (Marvasti, 2004). Many research settings can be considered as cultural groups such as nursing homes, hospital wards, clinics and intensive care units (Liamputtong & Ezzy, 2005). Ethnography is therefore a suitable research method to explore the cancer pain management strategies that nurses use in the Cancer Hospital in Sri Lanka.

3.6 Symbolic interactionism: Theoretical perspective for the study

Symbolic interactionism is the theoretical perspective of this study. Symbolic interaction has been defined as “a theoretical perspective comprised of interrelated sets of assumptions, concepts and propositions that constitute a view of the world and human behaviour” (de Laine, 1997, p. 61).

Due to the social problems arising out of industrialisation and urbanisation of the early 20th century, scholars developed a distinct theoretical perspective for systematic study of human behaviour that later was labelled as symbolic interactionism (Benzies & Allen, 2001). From this view point, it is believed that individuals construct their world based on their perceptions of that world. Symbolic interactionism helps to examine how people make sense of their experiences through a common set of symbols (Liamputtong & Ezzy, 2005). Three basic assumptions underpin symbolic interactionism. The first is that human beings act out of the meanings that things have for them. Secondly, human beings arrive at these meanings through interaction with others. Finally these meanings are assigned and modified as different events or aspects of an event emerge (Blumer, 1969).

Rock argues that “any research grounded in symbolic interactionism will be tentative, empirical and responsive to meaning” (2001, p. 29). The ethnographic form of inquiry utilised in this study collected data mainly via participant observation and

semi-structured in-depth interviews. By the very nature of participant observation, some of the assumptions which are related to matters of language as well as issues of interrelationships and communication can be observed. Symbolic interactionism directly focuses on language, communication, interrelationships and community. It is also about basic social interactions whereby an individual enters into the values and attitudes of a community (Crotty, 1998). Language, gestures, actions, objects and even silence can hold symbolic meaning beyond literal interpretation and they are able to be uncovered and their meaning interpreted. Symbolic interactionism therefore enabled uncovering the meaning/reality of nurse cancer pain management in Sri Lanka.

3.7 Role of the researcher

As an ethnographic researcher, the researcher is also an instrument of the research project and therefore is a participant. The concept of 'researcher as instrument' describes the significant role the researcher plays in analysing and interpreting the culture (Polit & Beck, 2008). There are three fundamental characteristics central to ethnographic research: the researcher as instrument, fieldwork, and the cyclic nature of data collection and analysis (Speziale & Carpenter, 2007). The researcher as an instrument needs to constantly reflect on the cyclic process of observation, data collection as well as data analysis to direct the research study in the way they wish the study to take them, in getting the level of insight into the culture they wish to obtain (Byrne, 2001; Carolan, 2003; Crotty, 1998; Morse & Field, 1995; Spradley, 1979, 1980).

Qualitative approaches have a connection with the subjective nature of social reality and provide 'insights' from the perspective of the participant. On the other

hand, the issue that the researcher faced with this study is that the researcher has had previous experience working in the hospital as a nurse therefore the researcher can be considered as an 'insider'. Being an 'insider' (emic perspective) helped the researcher to examine the experiences, feelings, perceptions and practices of the cancer nurses and the way in which they interpret events. Whereas an 'outsiders' view' of the world of cancer nursing, (etic perspective) does not enable such understanding easily (Polit & Beck, 2006, 2008). An insider perspective can benefit the researcher due to quick engagement into the ward environment from previous established rapport, with an easy transition into the setting and culture with the nurse participants, without the notion of being a foreigner in their field (Roper & Shapiar, 2000).

3.8 Data collection methods

There are many different data collection techniques that are used in ethnography such as watching, listening, asking and examining materials during fieldwork in order to survey the setting (Fetterman, 1998). According to Fetterman, the key to fieldwork "is being there" for the purpose of observation and asking "seemingly stupid yet insightful questions" (p. 19), taking notes and identifying those cultural influences created from what individuals say, do and act (Fetterman, 1998; Neuman, 2006; Spradley, 1979).

Concurrently during an ethnography study, data are gathered, transcribed and analysed throughout the study (Hammersley & Atkinson, 1995). Fetterman (1998) pointed out research triangulation is central to the reliability and validity of ethnography because it is not a particular method of data collection so combining data gathering method was important to this study. Brewer (2000) writes that the uses of

different procedural rules or methods in different methodological frameworks to study people in naturally occurring settings are legitimate in ethnography research.

3.9 Participant observation

In ethnography, learning about people's lives from their own perspectives and their own experience is undertaken. It involves not only talking to them and asking questions but also by observing them, participating in their lives and collecting information which relates to their situation (O'Reilly, 2005). "Participant observation involves not only gaining access to and immersing oneself in new social worlds, but also producing written accounts and descriptions that bring versions of these worlds to others" (Emerson, Fretz, & Shaw, 2001, p. 352).

Participant observation is the instrument used to collect data on the culture under study during field work. In this project, the researcher was a non-participant observer in the ward of the Cancer Hospital. A non-participant observer stance involves removing the researcher entirely from interaction and is confined to observations only (Spradley, 1980). One of the important qualities of an ethnographer is the ability to work with an open mind with the studied participants (Liamputtong & Ezzy, 2005). This helps the researcher to get close and observe the multiple realities in the field (Brewer, 2000). To achieve this, ethnography researchers immerse themselves in the culture to experience events in the same way as the local people. Through this immersion they are able to get deeper understanding of the people they are learning from, through seeing the things from the peoples' perspectives (Fetterman, 1998; Liamputtong & Ezzy, 2005).

Gaining access, learning the language, participation and observation and field notes are the key elements of participant observation (O'Reilly, 2005). Spradley

(1980) stated that participant observation has two objectives when entering a social situation: to be involved in activities appropriate to the setting and to observe the activities, people and physical elements of the setting. The author highlighted three types of observation techniques: descriptive observation where the social situation is described to determine what is going on occurs. Focused observation is where a focus on specialities in the field is paramount and selective observation which includes interviews and observations.

Overall, the role of the researcher involves observing and recording the relationships within the social scene and the description of the activities taken place in the setting in as objective a way as possible (May, 2001). Chapter four will describe in more detail the participant observation process undertaken during the study.

3.10 Ethnographic interviewing

To gain additional knowledge about nurses' cancer pain management practice, interviews were conducted with nurses and key informants. An interview can be described as a verbal interchange, in which an interviewer tries to elicit information, beliefs or opinion from another person's point of view (Burns, 2000). Adaptability is one of the major advantages of the interview where the interviewer can follow-up ideas, probe responses and investigate motives and feelings leading to in-depth knowledge on the area under study (Bell, 2005).

An in-depth interview aims to explore the complexity and in-process nature of meanings and interpretations that cannot be examined using positivist methodologies" (Rice & Ezzy, 1999, p. 53). It contains elements of structured and unstructured type questions in order to explore ideas with the participants but also to get fixed responses for some criteria (O'Reilly, 2005).

The advantages of interviews are that they allow participants to talk through the issue or subject of the interview in-depth. A semi-structured interview is less formal than are structured interviews (Wolf, 2007). Wolf further pointed out that ethnographic researchers might commence questioning informants with a vague idea in mind with questions gradually being more focused to enable greater understanding of the subject under investigation.

When interview responses are not in sufficient detail, depth or clarity, the interviewer must ask a probing question and may also request further evidence with some examples. There are three primary purposes for probing questions such as specifying the level of depth the interviewer wants, giving signal to the interviewee that the interviewer wishes more detailed information and encouraging the interviewee to keep elaborating (Rubin & Rubin, 1995).

The essence of the interview is the maintenance of an open approach which allows participants to bring their own perspectives in their own time as well as allowing the participants to raise issues that are most relevant. Prior to commencing a formal ethnographic interview, it is necessary to build good rapport with informants and remind them of the purpose of the interview (Wolf, 2007). Interviewing skills include silence, not interrupting the participant while they are talking and careful listening (Rice & Ezzy, 1999).

3.11 Sampling

Qualitative researchers develop parameters to specify populations and to choose and sample from these populations. Fetterman (1998) stated that ethnographers generally use an informal technique, namely judgemental/purposive sampling to begin

fieldwork. Purposive sampling is appropriate as it enable the researcher to access participants that are especially informative (Neuman, 2006).

A purposive sample of ten participants consisting of eight registered general nurses who had at least two years experience working as a nurse in the Cancer Institute in Sri Lanka as well as key informants including a pain clinic nurse and nurse educator occurred. Nurses selected as key informants had overall knowledge of cancer pain management in this cancer hospital. Therefore purposeful sampling of nurses' who had knowledge, experiences and attitudes regarding cancer pain management occurred in this study.

3.12 Data collection

Data collection was undertaken by the researcher at the Cancer Hospital, Maharagama, Sri Lanka from October 2007 to January 2008. The researcher spent over 100 hours observing in the field. Eight ward nurses and two key informants were interviewed. Interviews lasted one hour on average and were audio taped.

3.13 Data management

NVivo software for qualitative data analysis was used for this research study. Wolf (2007) stated that data management has been facilitated by computers, scanners, digital cameras, audiotapes and video tapes. Wolf further pointed out how qualitative software programs have been developed to assist the researcher in data management and analysis. However Rice and Ezzy (1999) contend that computer-managed data analysis requires additional resources such as software training as well as technical support. Learning any new computer-based software program is a very daunting

prospect (Bazeley, 2007). Using computer-based software allows storing data, coding as well as the ability to retrieve data more efficiently. Rice and Ezzy consider this process also tends to support “modernist assumptions about texts being representative of people and tends to disembodify interviews even further than physical transcripts” (1999, p. 204). Overall, data management with NVivo software was an easily managed process allowing all data to be investigated together. Data consisted of field notes, interview transcript and a reflective diary.

Overall the software assisted the researcher to manage the data by organising and keeping track of the many records including all data files not only from interviews and field notes but also reflections as memos, information about data sources and conceptual maps of what is going on in the data. By using the software, the researcher managed the ideas, queried data, created models and generated reports from the data as necessary. A focus on language, communication and interrelationship to develop meanings of the interactions was able to be achieved within the NVivo data management process.

3.14 Data analysis

Richard’s method of handling qualitative data and analysis was utilized in this study (Richards, 2005). According to Richards, thinking about handling qualitative data begins at early stages of the study. Data analysis occurred initially during the data gathering process, with themes emerging from field notes and gaps in the data being identified. However, the more formal analysis process occurred following the interviews. The entire field notes, interview transcripts, reflective notes were exported into NVivo on a daily basis. It helped to begin the analysis process throughout the data collection period as analysis is ongoing. The quality of the analysis depends on

the quality of data records as well as skills for working up from the data to express ideas and explanations (Richards, 2005) .

Richards's analysis method consists of time to read and think about the data; learning from the data and what it identified and what to take into the next research situation (2005). This purposive reading and learning aim to question the records and add to it, to comment on it and to look for ideas which lead up from the data to themes. Themes are common threads which runs through the data (Morse & Richards, 2002). Themes, according to Richards, usually mean something more pervasive than a topic or category.

When reading and reflecting on each data record, the result was a series of thoughtful summaries of events. These categories helped to build up codes. "Coding should always be for a purpose. It is never an end in itself" (Richards, 2005, p. 87). According to Richards, there are three types of coding namely 'descriptive', 'topic' and 'analytic' coding.

Descriptive coding describes a case (Richards, 2005). This study recorded the interviewees' information such gender, age, experiences and in-service education programs they attended under descriptive coding. Topic coding "merely allocates passages to topics" (Richards, 2005, p. 92) and it was the first step to more interpretive work. Reviewing all data word by word, line by line enabled considerable topic coding.

According to Richards, when comparing three sorts of coding, analytic coding is the hardest coding that comes from interpretation and reflection on meaning of the data (2005). After completing topic coding, the researcher began to undertake analytic coding considering the context and creating categories that expressed new ideas about the data.

Following Richards process, the researcher learnt to open up the data and develop his own ideas (2005). The technique relied on comparisons to help the researcher to find out what is going on in the data so if something is interesting, questions can be used to interrogate it. Through this simple process, the researcher can open up the data and enquire about broader aspects of the study. With this process, the researcher found text rapidly expanding with explanatory notes and memos.

Gradually memos grew to tell the story of data interpretations. Models were drawn of what was seen going on in the data. Modelling is a way of expressing ideas and like any expression, it clarifies ideas (Richards, 2005). They were also helpful to display and reflect on different ways of seeing the data.

The researcher generated ideas through the data and coding enabling reflection on the big picture, developing new categories and started linking concepts. Finally, revisiting the study aim and objectives and formulating the ethnography of cancer nurses' pain management approaches occurred.

3.15 Ethical considerations

Ethical considerations for this study are that nurse informants are also human beings who have interests, concerns and problems and the understanding that the researcher's values are not necessarily equal to all informants. As fieldwork is an important component of this research study, the researchers may confront conflicting values. For example: "How will I use the data collected and will I tell the informants how it will be used?" (Spradley, 1979, p. 79). It is therefore important for ethnography research to protect the physical, social, psychological welfare and honour the dignity and privacy of their informants.

Prior to the initiation of this research study, ethics approval was granted from the Human Research Ethics Committee (HREC) of Australian Catholic University (Appendix 1). The researcher initially obtained a letter with permission granted to conduct the research from the Director, Cancer Hospital, Sri Lanka, as the hospital has no ethical review committee (Appendix 2). Ethical approval from the Ethical Review Committee of Sri Lankan Medical Association was also granted to conduct the study (Appendix 3).

Bailey (2007) believes ethical considerations permeate all aspect of the field research process, from selecting the topic of the research study to disseminating the results. Consequently, as Sri Lankan nurses are not familiar with research studies they may be reluctant to participate in research activities therefore the researcher is required to fully explain the research activities and their risks and benefits for this study. The nurses were informed orally and in writing that they have the ability to withdraw from the project at any time, without penalty or coercion of any kind (Roberts & Taylor, 2002). Bailey (2007) pointed out that “informed consent is necessary when the research is more than observations in public places” (p.30). Informed consent was taken by using pre-prepared consent forms (Appendix 6) for the participant observations events as well as informant interviews.

The researcher appreciated the nurses’ voluntary participation in the study. As a consequence of what is customary in Sri Lanka, a very small present of a pen and file holder was given to participants as a small token of appreciation.

Confidentiality and privacy of all informant information was maintained in this study during the period of data collection and also in the writing of reports. Aggregated data has only been reported with no identifying information including name of ward used. Confidentiality was also maintained with consent forms securely

stored with principal researcher, separate from primary data. Pseudonyms were used for the informants to maintain confidentiality. All collected data were stored in a locked cabinet in the office of the Department of Health Sciences, Open University of Sri Lanka during the period of data collection. After completion of the data collection and analysis, primary data was transferred to Australian Catholic University, School of Nursing and Midwifery, research data storage area according to National Health and Medical Research Council guidelines.

3.16 Conclusion

The study methodology has been described in this chapter. Chapter four will present in detail the research process. Additionally, ethical considerations for the study have also been identified in the chapter.

CHAPTER 4

RESEARCH PROCESS

4.1 Introduction

This chapter describes the process that occurred during the conduct of the research in the field. The researcher, the role of the researcher in entering the field, participant observation, interviews and reflection of the research process will be presented.

4.2 The Researcher

The researcher commenced his career as a nurse after completing three years General Nursing Diploma at the Nursing Training School (NTS), Colombo. As a registered nurse, the researcher has experience in the fields of cardiology and neurosurgical nursing over six years. After completing one and half years Post Basic Nursing Diploma in Ward Management and Supervision, the researcher worked as a ward manager in Urological Ward at National Hospital of Sri Lanka (NHSL). Additionally, the researcher has obtained tertiary education qualifications including a Bachelor of Nursing and Diploma of Psychological Counselling.

The researcher whilst previously working as a nurse in National Hospital of Sri Lanka joined an educational project about cancer pain that was a collaborative link with a United Kingdom Cancer Pain Centre. The project focused on establishing a Cancer Pain Clinic in Sri Lanka. At that time, the researcher was involved in a quantitative research project by collecting data from 100 nurses exploring the nurses' awareness about pain management. The report of the research was published in the

Journal of Pain and Symptom Management in 2001. This initial research study led to the researcher's interest in this area of study.

The researcher's existing background as a nursing lecturer and previous role as a ward manager were an advantage to develop rapport with nurses in the field. It also helped the researcher to feel comfortable within the clinical setting and the terminology and operation of the field. An insider's perspective benefits the researcher due to speedy engagement into the environment with an easy transition into the setting and culture with the participants (Roper & Shapiar, 2000). Hammersley and Atkinson (1995) pointed out that ethnographers draw from their personal experience in the field and their reflections on the setting to drive and target the direction of the study. For this study the researcher had not been involved in cancer nursing and it provided the researcher with the ability to ask questions regarding cancer pain management and practices of nurses. "Knowing too much can foreclose in-depth conversations; knowing too little can appear rude and uninterested" (O'Reilly, 2005, p. 90). For this study the researcher's lack of nurse cancer pain management knowledge helped the research process.

4.3 The field

A useful definition of field research that was used to guide this study is that presented by Bailey:

Field research is the systematic study, primarily through long term, face-to-face interactions and observations, of everyday life. A primary goal of field research is to understand daily life from the perspectives of people in a setting or social group of interest to the researcher (2007, p. 2).

The field of this study is Sri Lanka with a large population of over 20 million people. Cancer treatment facilities are centred at the Cancer Hospital at Maharagama,

a suburb of the capital city of Colombo. This is the only hospital in Sri Lanka for cancer treatment with approximately 700 beds. It offers the complete range of cancer treatments including surgery, radiotherapy and chemotherapy.

Initial observations of the hospital include that the hospital is congested with various unplanned small buildings. Most of them are old with only the Out-Patient Department (OPD) having a new building. OPD has different small units including reception, health education unit, clinic rooms, counselling room and the dispensary. It is also very crowded, with many queues at the clinics and the dispensary. There are construction works going on in various places at the hospital. Overall, the hospital environment appeared to be not pleasant because of the busyness and congestion with patients.

Observation of the ward area identified that they are very noisy, especially medical oncology wards. The researcher selected a medical oncology ward to observe as it has many patients requiring cancer pain management. A surgical ward was not chosen as it has different categories of patients, some of them may not be diagnosed with cancer. Additionally, cancer surgical patients are transferred to medical/oncology ward for further treatment.

The cancer ward which the researcher selected was a large hall type female medical oncology ward with 58 beds. Thirteen nurses work in that ward including a nursing sister. This total of thirteen nurses rotated for three shifts per day 7.00am to 1.00pm, 1.00pm to 7.00pm and 7.00pm to 7.00am. They try to allocate at least 8 nurses for morning shift, 6 nurses for evening and 2 nurses for night duty. Therefore sixteen nurses are needed; however thirteen nurses fulfil this task by doing extra shifts. Consequently, most of nurses have to do double shifts. There are no swapping

systems from other wards or another institute to fulfil workforce needs therefore most of the time the ward is understaffed.

4.4 Entering the field

Access is not a simple process and is far more than gathering permission to conduct research (Hammersley & Atkinson, 1995). Permission to conduct the research at the Cancer Hospital in Sri Lanka was required. There is no ethical committee in this hospital therefore the researcher initially obtained a letter with permission granted to conduct the research from the Director of the Cancer Hospital. Important for this study was also to meet the gatekeepers such as ward manager, nurses and key informants to explain the study and the role of the researcher. Negotiating access was an ongoing process because of staff changes with shift rotations.

Permission from additional gatekeepers who are involved in the field such as Hospital Director, Section Matron, Ward Managers and Ward Consultant was also required. The present Director of the hospital was supportive of the study as was the ward sister. Due to a lack of research culture in Sri Lanka, some people were reluctant to participate in research studies. As the ward sister has a BSc Nursing Degree and good understanding about research activities, her supportive approach helped to facilitate the study in the medical oncology ward.

The researcher additionally met the Pain Consultant and Chief Nursing Officer to discuss the study and ask for support. Both gatekeepers agreed to give permission and support to conduct the study. An anaesthetic consultant acts as the Pain Consultant conducts a pain clinic at Cancer Hospital and National Hospital two days per week.

Gaining permission to conduct the study was a time consuming activity including many meetings with relevant persons. This process was successful in gaining access into the field. Therefore the initial stage of this project started well. However success in gaining access to the field is not a guarantee of success as good rapport with the entire ward community and the nurse informants was also required.

4.5 Participants

Before commencing the study, the researcher conducted an initial meeting with the relevant ward managers and nursing staff of the selected ward to develop an effective process for recruiting participants. The study was advertised on the ward notice board and participation invited from the ward nurses (Appendix 4). Information letters (Appendix 5) explaining the research project were handed over to the ward manager to distribute to nurses interested in participating in the study.

The researcher also contacted participants and nurse key informants individually and informed them of the study and invited their participation into the research. After they agreed to participate, a consent form (Appendix 6) was completed by the individual. Participants were thoroughly informed regarding the ability to withdraw or refuse to participate to this study at any time. Recruitment of participants continued until saturation of data occurred and no new information was found.

Eight ward nurses volunteered to participate in the study. The nurses were aged from 33 years to 42 years. They had worked in the Cancer Hospital for between 3 years to 16 years. There are two key informant participants: Pain Clinic nurse and Health Education nurse. The Pain Clinic nurse had 5 years experience and Health Education nurse had 13 years experience in the field of oncology. They have no

specialized education in their employment fields but have gained knowledge through experience and in-service programs.

4.6 Observation of participants

Participant observation takes much time. The researcher spent one hundred and six hours during three months in the field as a non-participant observer to gather data. The researcher divided the time between two hours in the morning and two hours in the evening as that was the busy time in the ward when nurses were providing care to patients. At times the researcher had to stay for a whole day to observe special events and procedures relevant to cancer pain management. Meanwhile, field notes of what was observed were being written. Time allocated at the beginning to enable the researcher to become familiar in the field and observe the culture of nursing cancer patients and pain management also occurred.

Having previous nursing experiences, familiarity enabled understanding of relevant terminology and language that relates to the cancer nursing and the hospital setting. That was very helpful and enabled building good relationships with participants in the field. However, the researcher had limited exposure to cancer nursing and that helped to maintain an observer stance.

As a non-participant observer in this study there was minimal harm or risk to the nurse participants other than the inconvenience of being observed and time spent being interviewed. Gaining access initially to the ward involved explaining the research openly and then settling into a semi-obvious role. In this situation, the participants knew what the researcher was going to do, but did not always have it in the forefront of their mind (O'Reilly, 2005).

The researcher selected an area of observation near the nurses' station that was non-intrusive to the activities of the ward. Minimizing obstructions and limited disruptions to the naturally occurring interaction of the nurses and patients, the researcher observed nurse-patient interactions from many different vantage points dependent upon the activities in the ward. These involved sittings on chair at the nurses' station or where the researcher was able to observe the patients and the nurses in the ward. Additionally, the researcher walked and stood in an out of the way area of the corridor in the ward when procedures were being undertaken with patients.

During the field work, data were collected gradually. A theme list to focus the study on specific aspects of nursing role was used (Appendix 7). The researcher used the theme list to observe a particular nurse cancer pain activity including analgesia, comfort and counselling. Additionally, notes in the form of diagrams, concept maps, key phrases and descriptive accounts of the ward environment such as smell, sight, hearing as well as feelings were written. These jottings lead to a more detailed account of the observational period once the researcher left the setting.

4.7 Field notes

Participant observation involves note taking which is an essential part of ethnography research. A field note is a document which consists of experiences and observations of the researcher that were taken in the field. Field notes contain not only the descriptions of what the ethnographer has seen and experienced, but also the ethnographer's perceptions and interpretations of the field (Liamputtong & Ezzy, 2005). This is not an easy process for a novice researcher.

The researcher wrote down the field notes as soon as possible after each observation experience. It was not possible to write field notes while observing,

therefore it was necessary to write the observations as soon as an opportunity arose to do so (Liamputtong & Ezzy, 2005). For the morning shift, observations were written at lunch time and in the afternoon. Whilst in the evening in a quiet space of the ward usually the nurses' room, field notes were recorded. A note book to record events that trigger memory, or short quotes, details such as date, names and anything else that was considered useful, was used during observation episodes (Brewer, 2000; Fetterman, 1998; O'Reilly, 2005). The note book was also used to make quick notes and draw a concept map as a reminder to write detailed field notes later. This concept mapping approach was easier than writing in a notebook and it was helpful to the researcher to develop detailed field notes later. Field notes also consisted of the dimension of personally experiencing and sharing every day life with those under study (Brewer, 2000). At the end of each day of observation, a diary with reflections on the observation session identifying questions and further data gathering required was written. It guided the researcher to enquire further into nurse's cancer pain management activities/events during the next observation session.

4.8 Interviewing

The interviews were approximately one hour in length, depending on the ability of the participant to participate. The main aim of interviewing is to capture the participant's perspectives in relation to their practice ideas, beliefs, values and behaviours regarding cancer pain management through their own words (Rice & Ezzy, 1999). Interviews for this study were guided with a pre-formulated interview theme list (Appendix 8). Rice and Ezzy (1999) pointed out that a guide theme list or inventory of topics helps to cover all relevant issues requiring investigating. On the

other hand, this theme list did not have direct questions but it acted as a reminder regarding the topics that needed to be considered while interviewing.

The interview questions were informed by the researcher's past nurse experiences and based on the literature review (Williams et al., 2001). For example, participants were asked what they knew about cancer pain, what the current practice in cancer pain management was and what kind of methods they used to assess pain. Probes used according to the situation such as "Can you tell me more about that? Go on, I see, and what happened then?" Though participants can use English as a second language, interviews were conducted in Sinhala language (Sinhalese), which is the native language in Sri Lanka as in-depth understanding about cancer pain management was required. Rice and Ezzy (1999) also pointed out the value of conducting in-depth interviews in the participant's own language. It was more successful because participants can express their own feelings as much as possible in detail and in-depth without any hesitation.

The researcher conducted all the interviews, this established good understanding and rapport with the nurses and key informants. Interview skills such as keeping silent, listening actively and not interrupting the participants while they were talking, were used (Rice & Ezzy, 1999). As a part of the reflexive approach to interviewing the nature of the interrelationship between researcher and participants was considered (O'Reilly, 2005). Reflexivity by the researcher ensured awareness of the situated understandings (Brewer, 2000) of being a previous nurse manager taking to practice nurses was taken into account.

All the face to face interviews were conducted in a pre-negotiated place on a date and time of the participant's choice. The Pain Clinic office, nurse managers' room and the Chief Nursing Officer's room were used according to the participant choice.

Those places were small, comfortable settings with few distractions (O'Reilly, 2005). All interviews were audio-taped. The nature of participant involvement and the potential risks were revisited prior to each interview and the granting of informed consent occurred. This interview process involved thinking, planning, writing, discussing with research supervisors, sorting through data for themes, reading notes and transcripts, thinking again and again prior to the next interview (O'Reilly, 2005).

All interviews were transcribed verbatim after every interview for later analysis. According to O'Reilly (2005), the researcher should do some of the transcribing as the process enables identifying themes and making connections. All interviews were transcribed by the researcher. This process helped the researcher to become familiar with the data and later know exactly where to find information.

4.9 Reflective diary

The researcher's reflective diary contributes to a major component of data collection. A diary was written after the interviews and after the each observation experience in the ward with reflections on the process and outcomes of the interviews and participant observation events. The reflective diary notes were not only what was observed and what participants said but also the researcher's thinking and feelings about what was heard and seen and its implications for the overall research study (O'Reilly, 2005). In fact, a reflective diary contained anything that was in relation to the study, whether during an interaction, after an interview, during a meetings in the ward or at the point of falling asleep at night. Keeping memos of such analytical ideas helped to form the beginning of the analysis process. The diary enabled a naturalistic approach in that over time participant observation incidents became familiar, the strange became usual and the impact of the study was traced to the experiences of

settling in and getting to know the environment/field (O'Reilly, 2005). The reflective diary also assisted the researcher to keep touch with his personal views and feelings within the study.

Richards (2005) pointed out qualitative researchers have to consider ownership of data. Data is made and worked with, reflected upon constantly and the part the researcher plays with data identified. During this study, notes were revisited and reflections drawn from them, especially during the data analysing phase. Notes were used to generate discussions with supervisors and colleagues. The use of a reflective diary also facilitated the process of monitoring the match between research topic, the nurses and their context (Hammersley & Atkinson, 1995). Overall, reflection was a major part in this study, from the beginning to the final report (Richards, 2005).

4.10 Evaluation of research

There is considerable debate over the criteria for evaluation of qualitative research. Any systematic attempt that present as description and explanation, whether quantitative or qualitative, needs to give answers to many critical questions for better evaluation (Silverman, 2006). In research, regardless of the research design and method, the researcher must explicitly state the evaluation criteria for the study's methodological quality (Silverman, 2006). On the other hand, nurse researchers must consider the truth value of the research and demonstrate that it is credible and valid for nursing practice (Holloway & Wheeler, 2002). Lincoln and Guba (1985; 1989) suggested criteria for evaluating qualitative research data. They are described under four areas such as credibility, transferability, confirmability and dependability.

Credibility or confidence is described as the data through sample selection presenting faithful descriptions and interpretations of participants' experiences

(Lincoln & Guba, 1989). In this study, the researcher built good relationships with the nurses that enabled trust to be established and for misinformation or distortions to be clarified. Member checks of data occurred as well as discussions with supervisors to conform credibility of data. Additionally, the theme list developed from the literature review provided confidence in the data collection process being reflective of the study aim.

Transferability refers to the extent to which the findings can be transferred to other settings or groups (Lincoln & Guba, 1989). While qualitative research does not aim to be generalisable (Holloway & Wheeler, 2002), the findings need to be evaluated in relation to applicability to other parallel cancer wards in this hospital as well as other cancer treatments units in other hospitals in Sri Lanka. The length of field work time supports the transferability of the data.

Dependability refers to the stability of data over time and conditions (Lincoln & Guba, 1989). Having only one person/the researcher collect and transcribe data can be considered to provide dependability of data.

Confirmability means that the research is free of biases and relatively value neutral (Holloway & Wheeler, 2002). In this study, the methods and procedures have been described explicitly and with sufficient information to demonstrate the sequence of the study. Member checks were conducted and memos written that also provide further evidence of the researcher's self awareness about assumptions and values, thinking and decisions throughout the process of data collection and analysis (Polit & Beck, 2006).

Through developing these evaluative areas the researcher has made a judgement of the trustworthiness of this study. Trustworthiness in qualitative research represent methodological soundness and adequacy (Holloway & Wheeler, 2002). By following

rigorously the research process, being supervised in this activity by Academics with higher education degrees, methodical trustworthiness has occurred.

4.11 Conclusion

This chapter described the research process undertaken during this research project. Entry into the field, engagement in the research process and finally evaluation of the study method has been discussed.

CHAPTER 5

FINDINGS

5.1 Introduction

This chapter describes the findings of the study which evolved from analysis of data following Richards handling qualitative data method (2005). Detailed description of analysis method has been provided in Chapter 3. This chapter is presenting what was discovered through analysis of data in a format that identifies the richness of the data.

Quotes of what participants said are included in the findings. Confidentiality has been maintained by reporting the quotes with interview date and alphabet code. Additionally, researcher's field notes and diary notations form aspects of the findings. Many of the quotes presented are grammatically awkward partly due to translation into English by the researcher. However the thoughts and the feelings of the participants are sufficiently well articulated to provide the meaning of their experiences.

One core category: The Nurse in Sri Lanka emerged from the data analysis with four sub-categories. Sub-categories influenced the care patients received by nurses at the Cancer Hospital and care provided by nurses. These sub-categories are:

1. powerless;
2. stuck in an unchanging situation;
3. health care situation in Sri Lanka;
4. cancer pain management.

Figure 1 present a model which illustrates the nurse and the connections between sub-categories.

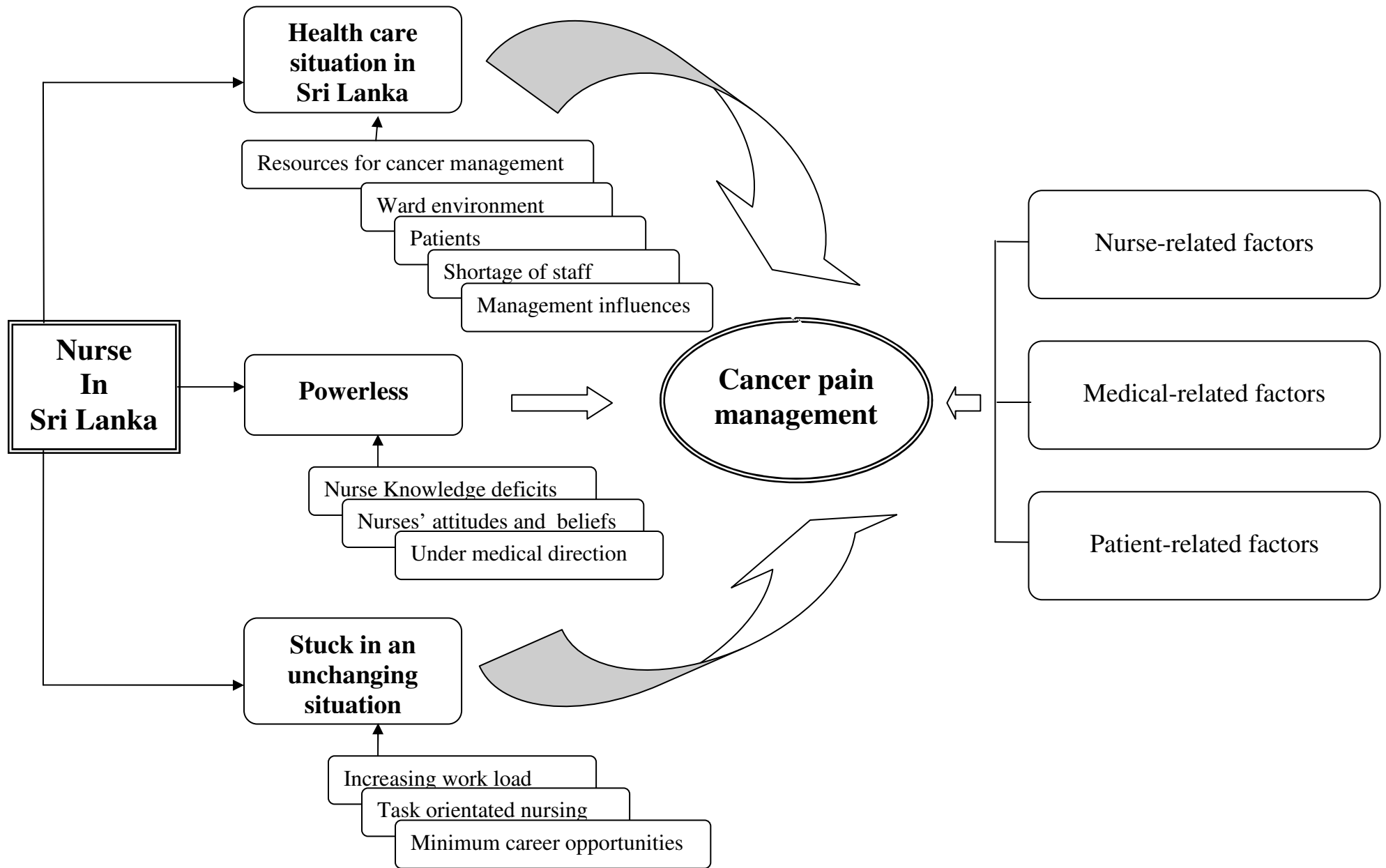


Figure 1: The nurse in Sri Lanka and the influences on cancer pain management model.

5.2 The nurse in Sri Lanka

The nurse in Sri Lanka has many roles. They provide care to patients by admitting to the ward, administering medications ordered by the doctor, coordinating paramedical services as well as supervising junior nursing and assistant staff members.

A description of the nurse in Sri Lanka presented by one participant, nurse D is that they are 'bulls tied to the cart'. A bull signifies the harsh role of the nurse whilst the cart is the ward and nurse duties. A bull is a beast of burden that performs work under the direction of a master. Bulls work constantly ploughing fields and pulling carts throughout Sri Lanka. It is an important part of the lifestyle for village people. For the nurse to be portrayed as a bull identifies him/her with a heavy workload directed by other forces such as hospital administration and medical staff. The nurse is not able to work independently and is completely task oriented. This participant's anecdote describes her perception of the status of the nurse in Sri Lanka as:

We can not go our own ways as we have to fulfil only the routine works in the ward. We haven't time to think about patients where they come from, what is the family history and even the patient past history of their conditions. I know it is important to know their socio-cultural background, as it is a help to effective pain management (Interview 06, Nurse D).

Not only is the nurse 'a beast of burden' but the environment he/she works in influences nursing care provided. The large hall type cancer ward is expected to accommodate 58 patients. However, on most days more than 70 patients are present in the ward. With the patients are accompanying family members. Nurses and doctors are also present in the ward. On one day, eight nurses were rostered to provide care for 97 patients. Most nurses were allocated over 12 patients but some nurses had to be released for ward rounds and other managerial routines such as referrals and ordering

drugs. As such, the nursing care provided was task oriented. It was such a busy environment with a lot of noise and activities as observed by the researcher:

I saw, the notice board is displayed today's total is 97 patients. This is the highest total since I came here. So the ward environment is so busy. The veranda/floor area is very crowded. Some patients haven't even chairs. Some people use mats and sit down on the floor. I went through the nurses' duty allocation book. There are 8 nurses on duty for the morning shift. All nurses look like very busy as they work quickly and go here and there. Today is also a ward round day for B side. B side total is 52 patients and A side total is 45 patients. The ward is very over crowded and noisy (Field notes, 05th November 2007)

The hall type ward can not separate or isolate a patient therefore nurses roughly divided the ward areas and beds to similar types of patients according to their conditions. Nurse E explained the situation and gave some justification for the patients' classifications and location in the ward.

Sometime according our resources of ward also affect to the patient. We keep leukaemia patient at the front side of the ward. And we keep other infected and some bad patients at the rear side of the ward according to their conditions. It is also affected mentally why we keep like that. But we have to separate or isolate some patients according to their disease conditions. Actually it is not doctors or nurses fault. It happens due to lack of resources in our country. We have these kinds of wards. We haven't cubicles. That's why. So some patients are on floor, or chairs. They are also suffering. But we can not do any thing. Patients total is very high, 70's but beds are 50s' in the ward. Physical as well as human resources are restricted. That is our country situation (Interview 02, Nurse E).

For one nurse I observed the many activities she undertook within two hours. Aspects of nurse's duty observed were the preparation and administration of cytotoxic drugs as well as care for patients. She also had to engage in paperwork, assessment of patients and assist the ward round. Nurses' duties also consist of being a pharmacist:

Though nurse C's duty is chemotherapy and side A, 1-15 patients, she engaged in other works. She took large ticket file from the nurses' station and went to the admission counter. I saw she put the date on continuation sheet of each ticket of patients. Meanwhile she called patients and asked from them whether bowel open or not and passed urine or not and marked it on their tickets. I also wanted to know what she is doing. So I asked about it. Then she told me she checked the previous notes of the ticket for any special things and put the date as the consultant came to the ward. She took all B side floor

tickets and wrote on them. After finishing those tasks she handed over the tickets to the relevant patients.

When she finished these managerial works of the ward, the time was 10.30 am. Then she went for her special procedure of chemotherapy preparation (Field notes, 05th November 2007).

A review of staffing in the ward was undertaken. It was found that an inadequate number of nurses were available to work. This is because of staff shortages. Nurse B described the situation in the ward as:

There are 7 nurses in the morning shift, 7.00 am to 1.00 pm; at least 5 for evening shift-1.00 pm to 7.00 pm and only 2 for night shift. But some days we can't arrange like this, see, today we have only 6 nurses for morning shift. So it very difficult to do ward like this. But nothing we can do (Interview 01, Nurse B).

Many of the nurses were observed doing extra or double duties. However, according to nurses F and G, they are not satisfied with this system. Dissatisfaction with rostering occurs as has been explained by these two nurses. The nurses are tired and dissatisfied with rostering and the work but the ward situation does not allow them any flexibility. The nurses are very committed to their work and they do their best.

We don't like to do this every day. But we cannot do anything. We have to do overtime duty to cover minimum members per shift. Otherwise we cannot do even routine works. When we do duty daily we are also fed-up and mentally depressed. I had done full day shifts/12 hours per day continuously 12 days. It was so hard (Interview 05, Nurse F).

On the other hand most of nurses do full day or extra night duties. So these nurses are also very tired and stressed due to their full of duty shifts. Actually I feel if we can work one shift per day, it will be more successful and it will help to overcome these problems and can do the work needfully (Interview 07, Nurse G).

On one day, four nurses were observed to continue their morning shift to afternoon shift. Therefore they had to work 12 hours continuously. Not only the morning shift but also the afternoon shift was busy with routine tasks. Most of the time nurses in the afternoon attended to referrals for other paramedical services such as X-rays, Scans

and Electrocardiogram (ECG) investigations. Patients were coordinated to receive paramedical services as ordered. This is an arduous task with many patients in the ward.

There were five nurses on the ward for evening duty. Four nurses continue their morning shift to the evening as I can see four nurses who also worked in the morning shift. Two of nurses take the drugs trolley. Other two of nurses take injection trolley, and the other nurse checked the tickets and sends the patients for X-ray, ECG and the other referrals. These five nurses are in the ward. There are no doctors or anyone at front side of the ward (Field notes, 29th October 2007).

Because of high number of patients in the ward, the nurses focused on routine tasks which are very relevant to patients' day-to-day treatments such as medication, injections and referrals. However, according to nurse D they do not forget to give attention to patients' hygiene though they have a few attendant/support staff to provide this care. Attendant staff undertakes personal hygiene of the patients if bystanders/relatives are not available. Nurse D describes the care she provides to patients. Care that includes routine activities as well as hygiene needs of individual patients and assisting attendant staff if required. Additionally, management of attendant staff is identified as another role of the nurse.

Generally 85-90 patients are in the ward. It varies on day to day basis. But 5-6 nurses are in a shift. So we have to do all routine works. As example if we come to morning shift we have to make beds, take blood for specimen and see to some patients' hygiene. As some patients have diarrhoea and they haven't bystanders, we have to do it. Most of the time attendants do it. But sometime we have to help them as they can't do alone. Especially some patients need special attention. At those times we attend it. As an example patients have bleeding tendency.... We can't hand over to attendants. Therefore such special cases are handled by nurses (Interview 06, Nurse D).

Nurse D further explained morning shift duties. The duties consist of record keeping, coordination of patient's referrals, chemotherapy and purchasing of drugs and administration as well as the health needs of patients involving side effects of cancer treatments. A system is in place that allows all these activities to be undertaken

for 80 - 90 patients in 2 - 3 hours. Senior nurses have specific duties with patient coordination whilst junior nurses attend to medications and patient hygiene needs.

This anecdote identifies the situation and workload at the beginning of the morning shift that nurses undertake in this ward.

Then we have to check the all tickets of patients and mark bowel open or not as bo/pu - bowel open, passed urine; what are the special problems such as If chemotherapy patients have vomiting?; what are the special investigations to do ; If patients keep fasting... Like that we have to check every thing related to patients. The ward round nurse or side nurses has to check these all things related to the patients. So the ward round nurse must know the patients current status, whether they complete all works of patients or they have to do today or tomorrow. Therefore two three nurses must check every patients every morning. It is very time consuming as the total 80 to 90s' so sometimes they have to check the tickets whether they need to bring the drugs today or brought yesterday. If patients have chemotherapy, take their name to the chart...and if finish the radiotherapy, we have to bring their cards from the radiotherapy department as we can discharge them in the ward round. So we send minor staff person to collect them. So many works we have to do. Therefore 2-3 nurses spend their 2-3 hours for these things in the morning. Especially ward rounds days are very busy. At least three nurses go to three sides; side A, side B, Floor patients to do these things. Most of the time senior nurses do these things. Other nurses also do morning routines; bed making; check patients' hygiene and arrange trolleys for medication, injections and chemotherapy. When they finish these things the time would be 8.30 or 9.00a.m (Interview 06, Nurse D).

Due to the large number of patients and shortage of staff nurses, it often takes over one hour to give oral medicine with two nurses. It was often hard to find the patients who are on the floor as they may be at X-ray or other paramedical service and therefore this task can be time consuming. Nurses call patient's name and give medication according to the medication chart to them or their bystander/relative.

Nurse D described the drug administration process:

Two nurses bring drugs trolley for medication. It is also taking over one hour as there are many patients on floor. Actually it is easy to give oral drugs for patients who are in the beds. If patient is not in the bed, we know patient is in toilet or bathroom. We can give after they come. But on the floor, we have to call the patients name. We don't know where the patient is. Sometimes patient is very near to us. But they do not respond or we didn't see. Therefore we have to spend more time (Interview 07, Nurse G).

Nurses need to give not only oral medications and injections but also chemotherapy drugs every day. Before giving chemotherapy drugs they have to start saline drips therefore they need three trolleys for injections, drips and chemotherapy drugs. First, they give injections and start saline drips for patients who need chemotherapy drugs. After that, the nurse who rotates every day for preparation and administration of chemotherapy drugs then starts to administer the chemotherapy drugs. This process sometimes takes an entire shift to complete.

Then we release one nurse to dissolve chemotherapy drugs. That nurse does it and gives them within her entire shift. Then one or two nurses go to the injection trolley. Sometimes two trolleys are used for injections and start drips. We use at least two boxes, 48 saline bottles per day. It also takes more time. Sometimes over 50 normal saline bottles are used per day. Dextrose, Lipofundine and also some other drips also continued or started, at this time (Interview 06, Nurse D).

One or two nurses generally help the chemotherapy nurse and they take two - three hours to dissolve the chemotherapy drugs. Nurse D identified problems for nurses with toxicity of the drugs, identifying allergic reactions. Though protection for chemotherapy drug preparation is available such as goggles, masks and gowns, they are not used properly. Due to the rush to finish the tasks the nurses do not care about these precautions as they feel uncomfortable with goggles and gowns. The following quote describes the situation of nurses' experiences of preparing chemotherapy drugs.

... See.... Sometimes one nurse has to dissolve chemotherapy drugs till at least 12 o' clock; we cannot tolerate these chemotherapy drugs long time. Sometimes some nurses feel eye pains, some have allergies. Though we take some precautions, it is too hard and risky for us.

...We can use goggles, masks and gowns. But gowns are not good. It easily gets wet. Even one drop of drugs drop on gown it will absorb soon. However, it is also useful, if drop or fall the toxic drugs to the gown we can remove the gown soon. Most of the time we use mask and gloves only. We don't use goggles and gowns as it is difficult to wear 3-4 hours continuously (Interview 06, Nurse D).

Nurses were also observed undertaking surgical procedures such as dressings. They do dressings for patients' wounds. Radiotherapy patients required dressings

because their skin was damaged by radiation. Nurse D described situations when patients required wound dressings.

Apart from that, though this ward is oncology medical ward, we have to put some dressings. Two nurses also need to do it. As an example now we have patient for radiotherapy. Her wound has bleeding tendency. So we have to change the dressing daily. There is another patient with large wound on her arm, it is also dressed daily (Interview 06, Nurse D).

The work of nurses with more patients than facilities to accommodate them was summarised by nurse A, who gave her views and suggestions on the situation. Due to this situation sometimes the ward environment creates or introduces new pain for the patients rather than managing their cancer pain. Therefore Sri Lankan nurses face many difficulties to manage cancer pain properly.

I think the number of nurses must be increased. But at the same time this physical environment must also develop, otherwise if we have enough nurses, how can we treat such patients without basic facilities? Many patients are on the floor. It is difficult to care for them. On the other hand if patient can rest on the bed they can tolerate at least a headache. But if they are on the floor, how can they tolerate even small pain? Sometimes we introduce some small pain, like backache due to this situation... So I think our resources must be developed. These are old buildings and their spaces are not enough for today. Today patients' number is also higher than the past (Interview 03, Nurse A).

The nurses are overburdened with workload, practise nursing in a difficult environment and do the best they can. The nurses are committed to work as they undertake double shifts and overtime. A system is in place for all routine nursing duties to be performed. From the analysis of the data it can be concluded that the Sri Lanka performs like a 'bull' with a large burden of work. The large burden of work consists of administrative duties, coordination of patients' paramedical requirements, supervision of junior staff, drug preparation, administration and ordering as well as nursing duties of assessing patients' health status.

5.3 Health care situation in Sri Lanka

This sub-category describes the current situation of health care in Sri Lanka. Various factors such as hospital and the selected ward environment, total number of patients, shortage of staff, management influences and resources for effective cancer pain management impact upon this sub-category.

5.3.1 Resources for cancer management

The hospital treats many people from all over the country. There are always many people and patients within the hospital premises. Most of them come for clinics, special investigations and radiotherapy treatments. They can be easily identified because they have cannulas, dressings and other tubes. Not only the patients and visitors but also many staff members can be seen in the corridors and outdoor areas of the hospital. Patients attend for referrals with units and departments within the hospital. These are some of the researcher's observations:

There are many people going here and there. Some are wearing white uniforms and they look like hospital staff. Some people sat down on chairs and ledges at various places. Most of them are wearing general clothes that are used at home. Some of them have plasters, some disabilities and clinical things like cannulas, tubes and dressings (Field notes, 17th October 2007).

This hospital has some old buildings with a new building for the outpatients department. Researcher description of the hospital included:

This hospital looks congested with various unplanned small buildings. Most of them are old. Outpatient department has a new building. It has different small units like reception, health education unit, clinic rooms, counselling room and the dispensary. It is also looks very crowded. There are many queues at clinics and the dispensary (Field notes, 17th October 2007).

As Buddhism is the main religion of the country, a small temple or the place to worship Lord Buddha is present in the hospital. There is a large tree called 'boe tree' which is used as symbol of Buddhism with Buddha's statues for worship close to the

main entrance. The patients and their relations use this temple to worship by wishing for an early recovery. The researcher observed many patients and visitors engaging with religious activities.

...there is a small temple with large 'boe tree'- a symbol of Buddhism. There are some people doing their religious activities in it such as lightening the lamps, offer flowers and praying (Field notes, 17th October 2007).

The limited space of the hospital and the many patients and people in its environment create a chaotic environment. Old and unplanned buildings present a poor image of the hospital. However, new buildings represent the gradual redevelopment of the hospital. The hospital provides a religious observance area which enables patients to make offerings. As many people use the services at the hospital, it is a well regarded hospital providing a level of care that patients require.

5.3.2 Ward environment

The medical/oncology ward selected for the study is on first floor of a two story building. This building has four wards; two on the ground floor and two on the first floor. It is also overcrowded and sometimes it was difficult to enter the ward due to many patients. There are patients without a bed, called 'floor patients'. They stay on the floor or on chairs.

The entrance of the ward is at the corner of the ward and it is so crowded. So many people are near the entrance. Some are sitting down and some are standing. Their faces look like they are very tired. Some are sleeping on the chairs (Field notes, 18th October 2007).

The ward is always busy with high number of patients more than the ward capacity of 58 beds. Bystanders and health care workers including doctors, nurses and attendant staff are also in the ward. Nurses and other health care workers are busy with patient care. Hospital management allows one person to stay with the patients to

help with the patients' day to day activities. Therefore the researcher observed the ward as busy and crowded with many people.

...can see many people in the ward and most of them are engaged in some work. Nurses, doctors, minor staff persons, bystanders and the patients can be seen. It looks very busy as well as very noisy (Field notes, 18th October 2007).

Some old fans increase the noise of the ward with the voices of bystanders and health care workers. Researcher field notes describe the noise level in the ward and the lack of awareness of the noise by nurses as they go about their duties.

Everyone creates a noisy environment. The fans add their sound and I can hear much sound in the ward. But all of these people- doctors, nurses, other staff and all patients do not care about it. All of them engage in their works. I think no one has time to think about their environment (Field notes, 18th October 2007).

The hospital and the ward environment do not have enough rooms and facilities for the large number of patients that are present. It is therefore always overcrowded and noisy with large numbers of patients, bystanders and health care workers including doctors, nurses and attendant staff workers in the corridors, ward areas and outdoor areas. The popularity of the hospital with so many people in its environs and the need for the services the hospital provides is evident.

5.3.3 Patients

A quote from Nurse F describes the numbers of inpatients in the ward on a daily basis. Despite only 58 beds, the staffs are expected to care for patients that are on chairs or even nursed on the floor. It is a chaotic and demanding environment for the nurse to work in.

...most of the patients are on floor or on chairs. Only 58 patients are on beds ...Sometimes our total is over a hundred. However there are generally 80 or 90 patients in our ward but few nurses are on duty (Interview 05, Nurse F).

An uncontrolled admission system is the main reason for the overcrowded ward. Most of the patients admitted to the hospital are through referrals from other government hospitals, through the hospital clinics and directly from consultant's private channelling system or their private hospitals. A patient can come and be admitted to the ward where they were admitted the first time. If a patient is registered under a consultant they always belong to that consultant and his/her ward. According to this system, hospital management cannot refuse patients' requests for re-admission. Some patients request re-admission for various complaints, even minor pain.

There is no control of the admissions to the ward. If patient register at one time to this ward under the consultant, they always come and are admitted this ward for their planned treatment as well as urgent or any other related treatments. I saw some patients come to the ward through directly channelled by consultant in private sector. However, I feel the hospital management or other managerial positions must think about this overcrowded situation of patients. There is no limit of this admission flow. Unlimited admissions increase the total of the ward (Reflective Diary, 01st November 2007).

Another factor influencing overcrowding in the ward are drugs issuing problems. Chemotherapy drugs are only issued before 12 midday. If a patient is admitted for chemotherapy treatment or the doctor orders chemotherapy after 12 midday the patient has to wait for one or two days for the drugs to be ordered. Permission from the Consultant and Hospital Director are required for drugs before pharmacy will prescribe. There are no computerized systems to order drugs. Nurses have to manually order drugs and send minor staff workers to respective places to get authorizations.

If patient admit to ward after 12 O' clock, we can't give chemotherapy, because doctor have to clerk the patients and chemotherapy drugs are not issued in the evening. Then next day we have to order drugs. So following day we will start chemotherapy. Then patient have to stay (Interview 05, Nurse F).

Due to number of patients and limited resources patients cannot get earlier dates for their special scans, investigations and also radiotherapy treatment. As most of the patients come from all over the country from long distances, they try to stay in the

ward till their date for radiotherapy schedule or other investigations or scans. There is no proper plan to minimize or control this situation.

Radiotherapy schedules also extend at least one month. Most of patients have to stay for one month in the ward to get their radiotherapy as they come from long distances (Interview 05, Nurse F).

Most of the General Hospitals have separate cancer treatment units. However, patients still come to this hospital as it is well known for cancer treatment. Not only the patients but doctors transfer the patients to this hospital when they diagnose cancer or after surgical treatments. Nurse G explained the current situation and gave some examples of other cancer treatments units which are attached to the general hospitals.

There are units for cancer treatment at general hospital in Kandy, Karapitiya and Anuradhapura. But most of the time patients are transferred direct to our hospital without transferring to those units... Those units are also completed now. There are several doctors at these units (Interview 07, Nurse G).

Despite the overcrowding doctors continue to admit patients to the hospital and patients continue to return despite alternative hospitals being available. The reputation of the treatment and facilities available at the hospital influences patient numbers and doctors' referrals. Poor management of patients' numbers also reflects administrative system problems in the hospital. Patients endure periods of hospital admission because of an ineffective chemotherapy drugs ordering process. Coordination of patient treatment regimes is also problematic resulting in extended hospital stays.

5.3.4 Shortage of staff

Despite large patient numbers, nurse rostering remains unchanged. Nurse B described the situation of nurse shortages to care for the large number of patients.

...only 13 nurses and including our sister all are 14... it is so difficult. But we can't do anything. If we want to increase nurses we have to do more over time duty. It is also difficult to do too much. Sometimes sister suggest to put three people at night. But no one likes to do it. ...Normally there are 7 nurses in the morning shift, 7.00 am to 1.00 pm; at least 5 for evening shift; 1.00 pm to 7.00

pm and only 2 for the night shift. But some days we can't arrange like this. See..., today we have only 6 nurses for morning shift. So it is very difficult to do ward like this. (Interview 01, Nurse B).

This shortage of nurses directly influences quality of caring and cancer pain management. The nurses have no time to do caring and they give more priority for routine duties. However, even the routine duties are often not on time due to many patients and shortage of nurses. Nurse C stated that this is worst at night because there are only two nurses on duty. Therefore the night duty nurses have to do more work.

When comparing our nurses in the ward with patients' total, today 94...One nurse has large amount of work. So we haven't leisure time other than doing routine works...But at night two nurses have to work twelve hours (Interview 04 - Nurse C).

Nurse B described the problems and workload on night shift. Two nurses have to give all medications and injections for all patients in the ward. Not only do they follow the routine tasks but they also have to attend to other procedures such as blood transfusions.

Only two nurses are working at night. We have to give so much blood for the patients at night. When we are giving oral drugs, sometimes we do not wake patients at night, so the drugs can not be given at a correct time. Sometimes patients wake up later then next drugs time is also close. In those situations drugs are not given the next time. It is also a problem (Interview 01, Nurse B).

Shortage of nurses and high patient numbers directly influences cancer pain management. Drugs are not given on time and doses are missed. Nurses work hard and support each other by doing many overtime shifts. Overtime is required to cover all rostered shifts. The nurses are committed to their work and do the best they can in the situation.

5.3.5 Management influences

Doctors have a major role in the hospital management system because they are the key persons who make decisions. The Director is a doctor and most of the ward consultants manage their wards by themselves. Consultants do not like other doctors or consultants to interfere in their patients' management. Nurse HE described how consultant doctors do not work cooperatively resulting in patient management patterns differing from ward to ward.

But our consultants don't work collectively. They do not also like to see their patients handled by other doctors or other consultants. They think they are the authorized persons so they work and handle their ward and patients in their own way. So sometimes some management is different from ward to ward. I feel this is not correct way but we can't do anything as they are the dominant people in our health sector.

... It may be influence for proper cancer pain management for in-ward patients... (Interview 10, Nurse HE).

An issue that is of concern to nurses is that of drug ordering and record keeping. Most of the time drugs are not issued according to the requested amount. Nurses who handle drugs at the ward level request drugs with doctors' written orders from pharmacy. The drugs maybe directly given to the patients or drugs can be used to maintain ward stock. However, pharmacists are always reluctant to issue the requested amounts of drugs. It is also a problem to manage cancer pain and continue other treatment. Nurse D describe the situation with the supply of morphine.

Sometimes if they give morphine, they don't issue requested amount. I don't know why they do it. When we ordered drugs most of the time we didn't get ordered amount; always less than the order (Interview 06, Nurse D).

Nurse E identified how the hospital management system creates difficulties for nurses with drug record keeping. Many drugs books have to be maintained with the counting and ordering drugs done by nurses manually. It is a time consuming process.

Actually there are some difficulties in handling drugs and ordering drugs according to these systems. We have to count all the drugs, order and balance the books, a lot of work (Interview 02, Nurse E).

Hospital management is strongly influenced by doctors. It is the doctors who administer the hospital. Nurses' problems of shortage of staff and overcrowding in the wards remain unchanged as the system supports doctors' needs. Nurses identify problems with management system especially ward overcrowding and drug administration processes. However, no change has occurred as the nurses' voice is not heard in the administration of the hospital.

5.4 Nurses are powerless

Powerlessness was a strong sub-category identified in the data. The nurse was powerless because of knowledge deficits and attitudinal beliefs. Additionally, working under medical direction oppressed nursing development. The following anecdotes illustrate the nurse and the connections between factors which impact on the nurses' powerlessness.

5.4.1 Knowledge deficits

The participants in the study have completed three years general nursing training in a government nursing training school. Nurses who work in the Cancer Hospital have only had general nursing training and have had no specialized education in oncology and cancer pain management. Nurse E and F highlighted their situation and pointed out the process they undertook to learn about oncology nursing.

I have completed my three years general nursing diploma. Then I got this appointment here as a nurse. Except this I didn't do any nursing related courses (Interview 5, nurse F).

Honestly speaking I haven't any oncology training. You know, this is the only one institute regarding cancer treatment in Sri Lanka. But we haven't any training regarding oncology. No one is here with such training. We have only our general nursing training. It hasn't also enough oncology nursing. Actually

it is a separate thing. We practice here through our experiences. If we want to know something we ask our seniors or refer the book. Otherwise we haven't any proper guidance to this work (Interview 2, Nurse E)

There are some in-service programs which are held by the hospital and give some introductory knowledge about cancer nursing including cancer pain management. It is limited education with a focus on newly appointed nurses in orientation programs. This is the only training program which helps nurses to practise as oncology nurses in this hospital. Nurses E and G described their experiences and which programs they had followed when they started work as oncology nurse at the Cancer Hospital.

Except for my 3 years general nursing diploma, I haven't any special training. I worked as a general nurse. However according to that institute I followed some in-service programs which was conducted by this institute. Otherwise I haven't any other special training (Interview 2, Nurse E).

However when new batch come to this hospital with their first appointment as a nurse after completing their government 3 years nursing diploma, we give one week in-service program for them including cancer pain management lectures (Interview 7, Nurse G).

Due to a lack of education, nurses learn to practice oncology nursing by observing senior nurses. The nurses then copy the senior nurses' practice. Because of this situation, nurses do not get new knowledge and practice remains unchanged. Nurses E and H pointed out they have no real knowledge about oncology nursing and they follow senior nurses. The nurses develop experience in oncology nursing through immersion in the field rather than education.

We also have not extra education than our basic education. If we have special courses we also improve the skills and develop trends to manage cancer pain. But we have not such courses or training programs here. We follow our senior and continue routine as usual. We have no real knowledge regarding oncology (Interview 2, Nurse E).

Though we totally work with cancer patients, we haven't oncology training. We do what our seniors do. We generally imitate our senior nurses. That is how we learn cancer nursing. Therefore we can't do many new changes of the practice. Everything goes on as usual (Interview 8, Nurse H).

During the three years general nursing training there is no cancer pain education in the curriculum. Though the nurses know the importance of managing patients' pain, they acquire this knowledge through their experiences and following senior nurses' practice. These two anecdotes from Nurses G and A acknowledge they have not had enough cancer pain management education during their basic three years nursing diploma program.

Actually they haven't proper education regarding cancer pain management. Our nurses didn't learn pain management even our basic 3 years nursing diploma. So we need sound ongoing education to update our knowledge about cancer pain management (Interview 7, Nurse G).

Nurses' education regarding cancer pain management is also important. Otherwise it is very difficult to handle or manage cancer pain. You know, we do these things through our experiences. No one gives proper education about it. We do these as our seniors do. Not only the cancer pain management but also we haven't got enough oncology training. We have only that our previous 3 year course. It was also not enough cancer knowledge as well as cancer pain management knowledge (Interview 3, Nurse A).

Some pain management education does occur but is limited to a one hour lecture which is conducted by an anaesthetic consultant (Madam) or Pain Registrar from the Pain Clinic of the Cancer Hospital. This is the one source of knowledge for nurses about cancer pain management. The education is held every month. In-service lectures were attended on cancer pain by Nurse A:

Generally pain registrars do it. Here we have on-call pain registrar when they come to our hospital they do one lecture for nurses, 3rd week of every month. It may be one hour. They try to give basic knowledge about cancer pain management (Interview 10, Nurse HE).

I did not study about pain but I participated in in-service program that was conducted in this hospital and they have some lectures regarding cancer pain management... (Interview 3, Nurse A).

Nurses believed the lectures are at very introductory level and focus on the same content in every lecture. Most lectures are focused on drug therapies and the World Health Organization's analgesic ladder. Though the lectures continue every month,

they have not promoted change in nurse practice as many other aspects are required to promote change; aspects including a system to initiate change in the ward. Nurse D has an experience of these pain lectures for nine years.

Those lectures were mainly focused on drugs therapy like... how to give drugs and introduce drugs such as morphine sulphate and explain the analgesic ladder. Those lectures were not focused to our practice in the ward. Actually I participated within my nine years in these lectures. But every time they describe these same thing like analgesic ladder and its' drugs, it was a basic introduction. Recently I also participated in those lectures. That was also same content (Interview 6, Nurse D).

Though most of the nurses have attended the one hour pain lecture, they do not change their practice in the ward. Nurse PC considered this was due to the minimum practice of cancer pain management in the ward with the nurses soon forgetting the theoretical knowledge. Nurse PC considered the workload was a factor in the resistance to change practice.

Sometimes due to minimum practice of pain management in the wards, they forget that knowledge gradually. Actually if pain management is actively functioning in the ward, this theoretical knowledge can apply; otherwise they forget that new knowledge. From time to time there are in-service programs and every in-service program include pain lecture. But our nurses do not use that knowledge practically. Sometimes it may be the heavy work load. I don't know... (Interview 9, Nurse PC).

Knowledge deficits and a lack of commitment to change practice were evident during analysis of data. Mostly the nurses copied senior nurses' practice as they had received no formal oncology nursing and cancer pain management education. The ward situation, staff shortages all had an impact upon cancer pain management.

5.4.2 Working under medical directions

All management positions in the Ministry of Health are held by doctors including the Secretary. Hospital directors are also doctors including at the Cancer Hospital. Every ward also has one or two permanent consultant doctors and those consultants

manage the patients and the ward. The ward consultants influence the workload and nursing powerlessness situation. Nurse H felt the medical professionals did not respect other health-related professions.

... Consultants work their own ways. They try to manage the hospital their own ways and interfere with everything. Our health service is a doctors' dominant one. They don't like to respect other professions. They think they are the dominant people specialized for different fields (Interview 8, Nurse H).

Some consultant doctors do not like the involvement of pain clinic consultant, nurse or other pain registrar doctors to manage patient's pain in their wards without their permission. If a consultant is such a person, the pain clinic staffs do not approach the patients in that ward. The ward doctors and the consultants never refer their patients to the Pain Clinic. They attempt to manage patient's pain by themselves in the ward.

Some consultant doesn't like the involvement of pain clinic to their patients' pain management. On the other hand, according to my knowledge there are no proper circulars or protocols for these things (Interview 10, Nurse HE).

Additionally medical dominance consists of some consultant doctors not giving any support to build a pain management team. The consultants are resistant to implementing pain doctors' plans because they think they can manage patients' pain as well as cancer treatments. The consultants consider they are both oncologist and cancer pain experts.

Some time our consultant oncologists think they can manage cancer pain in their wards. So they do not give enough attention to develop pain team (Interview 10, Nurse HE).

Nurse H believes some doctors feel nurses have to follow only their instructions and have no right to request pain medications for patients. Doctors think the acceptance of nurses' suggestions harmful for their status because they believe nurses have to follow their instructions. Nurse H presented her views on the situation and she also emphasized all doctors are not like that. For Nurse H oppression by doctors over

patient's pain requirements was problematic. This anecdote identifies the medical forces Nurse H works within.

Actually there are some influences from doctors sometimes. I mean when nurses inform to doctors about patients' pain or suggest something to do or give pain killers.... Sometimes some doctors do not like to accept nurses' responses. I think most of doctors in our field think they are the prominent people So they do not like to get nurses suggestions. They consider nurses have to follow their orders. But ... all doctors are not like that. At last they do something for pain (Interview 8, Nurse H).

Sri Lankan nurses feel unsupported with their professional role because they are always influenced by medical professionals. Most of the time nurses have to conduct their role under medical directions. Therefore nurses' cancer pain management practice depends on doctors' directions and control.

5.4.3 Nurses' attitudes and beliefs

All nurses who work at the Cancer Hospital have no nursing specialisation other than the limited in-service programmes which are conducted by the hospital health education unit. The nurses do not feel they are in a profession. Most of them think it is just an employment. They come to the job every day and do extra shifts focusing on routine work to obtain more money rather than thinking about professional career development. They have no appraisal system after getting their permanent appointment at a Government Hospital. Nurse H described the attitudinal situation that nurses have:

Some nurses just think this is a joband focus only for money. On the other hand, there is not any assessment or evaluation system for nurses. If they get an appointment, they can continuously work for years and years... (Interview 8, Nurse H).

Most countries allow nurses to give some medications for patients if required such as paracetamol. It is generally known as nurse-initiated medication. That means they

have limited permission to prescribe certain drugs. Sri Lankan nurses have no right to give any kind of medication without a doctor's written order. Even if patients complain of minor pain the nurse must inform the doctor and wait till the doctor orders the drugs. Nurse C explained the current practice.

Most of the time doctor orders painkillers, oral or continuous drugs to manage pain. You know here we can not give any drugs without order from doctor. So we use this practice (Interview 4, Nurse C).

Decisions related to hospital management and nursing related issues are made by the doctors, consultants or the hospital management. Nurses' involvement in decision making is minor. Even when planning patients' treatments the patient is not part of the process. The doctors make the decisions about a patient's treatment without the participation of the patient or family. Nurse HE believes patients should participate in decision making about their treatments.

Here, we make the decision and implement it to patient. Actually we also do not participate to make decisions as nurses. Only doctors do it. But I think according to correct method, patient should participate to make decision. We also have to ask from the patients about their ideas and what they like (Interview 10, Nurse HE).

Powerlessness of the nurse is evident in their lack of decision making. All decisions are made by medical staff even though the decision can influence the role of the nurse. Oppression by doctors, a lack of control influenced by knowledge deficit and poor professional nursing attitudes are obvious factors impacting on nurses. These factors appear to result in poor cancer pain management for patients.

5.5. Stuck in an unchanging situation

For the nurse at the Cancer Hospital he/she is stuck in an unchanging situation as has been identified by medical dominance and minimal acknowledgement of the value of nursing. The nurses are 'stuck' because of workload, task-oriented nursing practice and minimal opportunities for career development.

5.5.1 Increasing workload

Due to a lack of an effective strategy to control the admission of patients, workload is always arduous in this ward. Few nurses can tolerate the workload in the ward. Nurse A felt this workload is much more than many nurses can tolerate.

See our ward; there are many patients in our ward. Nurses can not tolerate their workload. Nurses have more workload than they can tolerate. ...Today patients number is also high than the past. That's why.
(Interview 3, Nurse A).

Nurses' workload takes much time to fulfil because of procedures such as medication, injection, chemotherapy and other various patient related tasks such as blood transfusions. Nurses also have to act as coordinators of the care and they need to contact other related sectors to send the patients for radiotherapy, scans and biopsies. Nurse E explained their working situation and she highlighted how nurses have no time to talk with patients.

It is a great effort to find a floor patient to give drugs. Most of the time ward total is over 70. So it is very difficulty to work. When we start to give drugs we have to spend at least one hour or one and half hours. Then we have to give chemotherapy, blood, injections, antibiotics and also send referrals. We have to send patients for radiotherapy, scans and biopsies. So we haven't time to talk with patients (Interview 2, Nurse E).

Nurse H also described the sympathetic staff who do not have enough time to talk with patients. Patients are acknowledged as needing psychological support from the

nursing staff but due to the heavy workload, this does not occur. This anecdote from Nurse H describes the situation that a large workload forces upon nurses:

I think, though we have good kind staff, due to their workload, they haven't time to give psychological support for the patients. (Interview 8, Nurse H).

The heavy workload of nurses also does not allow time for giving attention to patients' pain. Patients with severe cancer pain need more attention and good psychological support. They also need pain relieving drugs at correct times but there is no special attention for such patients.

Sometime due to heavy workload we haven't time to give more attention for such pain patients. (Interview 4, Nurse C).

The researcher observed when patients complain of pain if it is medication time. Nurses give oral and intravenous medications according to the doctors' orders. Then all nurses attend other procedures such as oral medications, injections and chemotherapy drugs and forget to follow up the patient in pain. Actually, they have no time for it. There is no follow up system or assessment system after or before routine medication administration duties.

After giving oral and intravenous pain killers for the pain, the patient slept well. All nurses are in the ward. They were giving medications, injections and also chemotherapy drugs. Due to their works with other patients, no one comes and sees the patient again, how was the pain of that patient? However patient was also in the bed. She had comfortable sleep. Patient did not complain pain again within those 3-4 hours. (Field notes, 13th December 2007).

The impact of a high workload is that nurses are not available to give psychological support and drug therapy to patients experiencing pain. No evaluation of pain therapy was observed. Routine nursing tasks are all nurses have time to undertake.

5.5.2 Task orientated nursing

Nurses accept that they have not enough time for nursing care. Their shifts are full of different nursing tasks. Nurses do many procedures and treatments for patients but they do not have enough time to spend with patients. When few nurses are working with large number of patients within the hall type ward, they have to give attention to the entire ward rather than individuals. Therefore nurse-patient relationships are not strong. Some of main ward routine tasks include medication administration, injection, chemotherapy, radiotherapy, dressings, specimen collection and referrals. Nurse C felt it is very difficult to cover all these main routine tasks within their duty shift.

Actually we haven't time to do nursing care. Now you know sometimes we take over one hour to give medication. Injection is also like that. Then we have to give chemotherapy, send patients for radiotherapy and other referrals. So many routine works we have to cover with in our six hour duty. (Interview 4, Nurse C).

Nurse F also mentioned there are not enough nurses on the shift to cover all routine tasks. All nurses give their attention to finish the tasks within their duty shift. This often results in patients not getting adequate attention. When nurses finish their major tasks they have also nearly finished their dayshift.

Actually these nurses are not enough for the shifts as patients total is high. Then our attention for one patient is also reduced, and we think about to finish our work load. When we do the routine works, our duty time is over (Interview 5, Nurse F).

When nurses are engaged with patient-related procedures such as medication and injections, nurses were observed not to talk with patients because they want to finish it quickly as they have many other tasks to fulfil. The researcher noticed when a nurse was taking a blood specimen the patient wanted to talk more with the nurse but the nurse did not want to continue the conversation because she wanted to move to the next task.

Within this procedure nurse asked about patient's conditions and how everything was going on. Patient's reply was it that everything was going well. I noticed the patient talk with pleasure with a smile. She tried to talk continuously but after finishing the procedure nurse wanted to move from the patient. So the conversation had to stop. I feel patient wanted to continue it but nurse had to go her task (Field notes, 05th November 2007).

Task-oriented nursing occurs because of workload demands with many tasks to complete in a defined period of time. The nurse must work quickly and efficiently to complete all the tasks. As the nurses have been educated to copy senior nurses' practice, the situation remains unchanged. Maintaining traditional task-oriented nursing practice continues in such an environment.

5.5.3 Minimum career opportunities

Due to the heavy workload, nurses have not enough time to do any other studies or participate in in-service programs. They are stuck in an unchanging situation in the ward as a general nurse. Nurse G has 16 years experience as a nurse but she is still a general nurse. Nurse H has 14 years experience in the Cancer Hospital and is still a general nurse.

I have 14 years experience in this hospital. If count my nursing training period, it was 17 years. I am from 1990 batch. (Interview 8, Nurse H).

Though these nurses have given long service to the hospital and gained a lot of experience in this field, they have not been afforded the opportunities for career advancement. After they register as a nurse, they are able to participate in one or two in-service programs within the hospital.

I had also done three years diploma in nursing. Other than this general nursing diploma, I haven't done any nursing related courses. I have been working here as a nurse since 1992. Within this period I participated in some in-service programmes related to cancer nursing that was held by our hospital. (Interview 7, Nurse G).

The nurse in Sri Lanka has minimal opportunity for career advancement to the level of ward sister or matron. Nurses are needed in the workforce and so they stay at the same level for many years. Specialization areas in nursing are limited. The future of a nurse is that they continue to work overtime, be dominated by medical staff and have minimal control over their work situation. This environment results in a lack of professional regard as a nurse and attitudinal beliefs of being a non-professional, only able to perform task-oriented nursing.

5.6 Nurses' cancer pain management

Cancer pain management is influenced by the situation that nurses work in. Being powerless, stuck in an unchanging situation and working in a health care environment with minimum resources impact on pain management. Three main factors influence nurse's cancer pain management: nurse, medical staff and patient.

5.6.1 Nurse-related factors

All nurses interviewed acknowledged that pain is experienced by cancer sufferers. Nurse C believes cancer pain has physiological as well as psychological effects. Many different beliefs about cancer pain were put forward by the participants. Physical aspects of pain would relate to treatments and effects of the cancer growing and spreading throughout the body. Psychological effects maybe life threatening because a diagnosis of cancer in a country with minimal resources to treat the condition can have serious consequences.

I think cancer pain affected cancer patients severely. It affects not only physically, but also mentally. I think psychological pain is most important. When they hear about cancer they feel half of their life is lost. After added

physical pain, cancer pain is big issue for them. So we have to treat or relieve the cancer pain totally. I think as a nurse, it is our duty (Interview 4, Nurse C).

For Nurse HE, the type of pain experienced by patients has been also identified. Physical pain presents from cancer metastasis, surgery and treatments. As well as physical pain, the mental health of patients and the need for palliative care was described by the participants. The nurses considered that patients should not tolerate pain as it influences their quality of life. Nurse HE explained the stages of cancer and emphasized the importance of managing cancer pain especially for palliative care patients.

I think it is very unbearable pain. If we take cancer patients, one third of them are curable, other one third of patients' life time can increase given cancer treatment and the other one third of patients are palliative. This last one third of patients comes with cancers that have spread and suffering from severe pain. They need palliative care and also cancer pain management. Actually not only them but also other categories of patients need cancer pain management in their various stages of treatment. As an example patients who face surgery or other special procedures. When we consider 'quality of life' of these patients, I think pain management is very important. It is also very helpful to maintain their mental health. Otherwise they have suffered with pain physically as well as mentally (Interview 10, Nurse HE).

Despite Nurse HE acknowledging patients' pain, the current practice of cancer pain management observed by the researcher was variable. Some nurses provided pain assessment and medications whilst others continued to focus on routine tasks and did not acknowledge pain needs of patients.

Nurse E came to the bed no. 1 and checked her ticket because of complaint about pain. Then she went back to the drugs trolley and chose some drugs for the patient, according to the ticket. Then she come back to the patient and asked to take the drugs. She further explained that drugs help to reduce her pain. Then the patient tried to sit down on the bed very slowly. Nurse E gave her hand and help to sit down. Then she gave the drugs to the patient. She used a water bottle that was on the patient's locker, to give glass of water to the patient. Patient took the drugs with water. She thanked to nurse E for her help (Field notes, 13th December 2007).

There was a patient on the floor and groaning in pain. The nurse E told she will see her later. Four nurses discussed how they work today as shortages of nurses in the morning shift. Nurse D told they can share their duties. Then

nurse A told she can check the bed head tickets and referrals, especially investigations and radiotherapy patients who can be sent for the relevant places. Nurse C and D went to bed making procedure (Field notes, 12th November 2007).

Current practice about cancer pain utilizes mostly drug therapy. When a patient is admitted to the ward with pain, doctors order pain relieving drugs including simple pain killers such as paracetamol and then increase to other pain killers as required. Nurses G and H give some examples of pain relieving drugs ordered and their usage patterns.

After doctor examines the patient and clerk the ticket, we give pain killers to the patient according to the patient's ticket. Most of the time, we start from paracetamol. Then, we give tramadol, carbomezaphine and morphine sulphate (Interview 7, Nurse G).

Actually most of the times we use drug therapy to manage pain. Generally first we give Panadol and then gradually we give Morphine sulphate (Interview 8, Nurse H).

The researcher observed the pattern of initial pain management in this ward. If patients complain of pain, nurses do not assess the pain. They inform the doctor of patient's pain. The doctor will then order or increase the pain relieving drugs sometimes without patient assessment. General pain assessment is patients' presentation or complaint of pain. Doctors also order stat doses of drugs to manage pain without further planning.

Nurse went to the doctors' station and told the doctor about the request of some pain killers of the patient as she has severe pain. She further told the doctor that mother has already taken paracetamol and tramadol. Then doctor went through the patient's ticket and the drugs chart and added Morphine sulphate to it. Then the doctors also told the nurse, if it is also not answered, they would refer to pain registrar later. Nurse further told the doctor, she thinks patient is also depressed. Then doctor went to the patient and examined the patient. After that the doctor discussed with the bystander. Then doctor said to nurse 'don't worry, we will see it later first we try to manage pain. You can give stat dose of morphine now.' (Field notes, 22nd November 2007).

Pain relieving drugs are also ordered at different times other than the routine times. Due to the different time frames, shortage of nurses and high total of patients, nurses do not often give pain relieving medication at the correct time to the patients. The nurses use bystanders to remind them of the correct time to give the drugs or they give the drugs to bystander to give the patient at correct time.

Most of the time patients have answered to their pain because these drugs are ordered at different times according to their pain. But most of the times we cannot give these drugs at a correct time. So we give drugs for bystanders to give patients at a correct time...One, drug gives at 8.00am; other one 10.00am... like that there is a time gap between these drugs. Generally we give drugs for patients at 8.00am as routine procedure. So if there is a drug at 10.00am we give it to bystander if patient has a bystander otherwise it can be missed. Generally when we give the routine drugs, we have to spend at least one hour. That is the situation (Interview 5, Nurse F).

Most of the participants described the current practice of pain management on the basis of drug therapy. Nurse C described the situation of managing pain by doctors increasing and changing pain relieving drugs. Nurses cannot give any drugs without an order from doctors. However, if a patient does not respond to the drugs they may refer the patient to the Pain Registrar or Pain Clinic. This system is ad hoc and does not provide continuous effective approach to managing patient's pain. No evaluation of the effectiveness of drug therapy occurs. Action is only taken when a patient complains of pain to the nurse.

Most of the time doctors order painkillers, oral or subcutaneous drugs to manage pain. ... Here we can not give any drugs without order from doctor. So we use this practice. If patient doesn't reply these drugs. Doctors refer the patient to pain registrar. Then pain registrar sees the patient and again order pain killers according to patient pain. If pain registrar thinks of further management they ask to send to Saturday pain clinic...Actually, this is our routine system; within this system we haven't separate time to manage patients to relieve the pain. Just we give drugs according to their tickets as routine procedure (Interview 4, Nurse C).

Within the current system of cancer pain management in this ward, most of the nurses do not consider patients as individuals. They think of them under the label of

'patients'. Some nurses think patients are shouting unnecessarily, when the patients have already received pain killers. They do not understand the concept that 'pain is highly individual'. Nurse H said that all patients are not same. The nurses do not understand the patients' state of mind and pain tolerance levels.

Sometimes I noticed our nurses comparing patients doing pain related procedures, or giving advice. As an example, when inserting a cannula or taking biopsy they said that, 'see, that patient is good, she did not shouting in pain so why are you shouting. This is same procedure' ...like that .Actually some nurses doesn't think that pain is an individual experience (Interview 8, Nurse H).

Most of the nurses have no idea about break-through pain and they do not plan for it in the ward. Some nurses have not even heard the word. Ward doctors also do not plan for break through pain to manage patients' pain. They try to manage patients' pain using different pain killers in different time frames or giving stat doses. Nurse PC pointed out sometimes patients are also reluctant to get drugs within the doses as they think it is dangerous but due to this practice, some patients have to wait with pain till next dose. Nurses PC and E described their experiences related to break-through pain. Only Nurse PC has an idea about break-through pain due to attendance at pain lectures.

I think most of time patients missed their night doses and they do not take drugs at correct times. Some times if patients have pain within the drug doses, they don't like to take next dose till correct time. Even our nurses also do not give pain killers if patient complain the pain within doses. However, Madam explains in pain lectures if patients have pain they can get next does before the next dose time (Interview 9, Nurse PC).

...we can't give without order. If doctor do not order we have to wait for routine dose. Sometimes they order another pain killer. However it depends on doctor (Interview 2, Nurse E).

Nurses are involved in the management of cancer pain as a secondary process. Primary responsibility with pain management is with medical staff that order drugs and make referrals to Pain Clinic. For nurses, pain management means the

administration of drugs. Psychological pain is not addressed by the nurses. Pain management is not planned and assessment and evaluation of drug therapy does not seem to occur. The consequence of this is that patients are in pain.

5.6.2 Medical-related factors

Doctors are the main agents in managing cancer pain. They are the people who make the decisions and order pain killers to relieve patients' pain. When patients are admitted to the ward, they try to manage patients' pain in the ward. If they can not manage pain in the ward then they refer patient to Pain Clinic or Pain Registrar. However, according to Nurse HE, some ward doctors do not like to refer patients to the Pain Clinic, they try to manage patients' pain by themselves in their wards.

When patients admitted to the ward doctors try to manage that patient's pain in the ward by giving some pain killers. If they feel they can't manage it in the ward then refer to pain registrar or pain clinic. I don't know, every ward does like this, because some wards do not like to refer to pain registrars, they try to manage themselves in the ward (Interview 10, Nurse HE).

There is no good cooperation with the ward doctors and the Pain Clinic doctors regarding cancer pain management. This also influences successful pain management. Due to this situation nurses also have to accept their ward doctor's control over patient's pain needs. Nurse PC explained the situation:

... Some pain registrars complain with us, when they go to some wards and introduce themselves coming to see pain patients.... some nurses say there are no pain patients to see, I think those ward doctors do not like pain doctors with interfere their management (Interview 9, Nurse PC).

Doctors are also not well educated regarding cancer pain management as it is not a separate acceptable service in Sri Lanka. However, using different pain relieving drugs, they manage patients' pain as well as possible with their limited knowledge. Nurse H emphasized the importance of pain education for doctors as well.

Most of the time doctors haven't a good idea regarding pain management. If patient complains we give pain killers for it. That is the pain management here. There is no scientifically way how to manage cancer pain. Somehow they try to manage the pain. I think doctors also need training or education regarding cancer pain management. If doctors are knowledgeable they can order or can implement any procedure as nurses are ready to follow the doctors' order. (Interview 8, Nurse H).

Pain clinic consultant and pain clinic registrar try to manage patient's pain by giving oral pain killers or subcutaneous drugs such as morphine. If they can not manage with oral or subcutaneous drugs they use epidural catheters or nerve blocks to manage severe pain. These procedures are not commonly seen. Nurse D pointed out when a patients cancer is at the terminal stage more intensive pain management can occur. However this is rarely seen in the wards.

Most of the times they use drug therapy to manage the pain but very rarely use nerve blocks or epidural lines. It also depends on patients' situation. If patient cancer spreads or prognosis is bad, they do everything to relieve the pain. Otherwise I don't see them do these treatments. Actually if patients' prognosis is bad, pain doctors try to keep the patients free from pain. So at that time they do nerve blocks or epidural lines to manage such pain. However it is very rarely seen. Patients with epidural catheters are managed by ICU anaesthetics doctors (Interview 6, Nurse D).

According to Nurse G, though nurses can give subcutaneous morphine they can not insert drugs to epidural line. Therefore pain doctors or Intensive Care Unit (ICU) doctors have to give it. This is problematic as ICU doctors may not be available when needed because of other duties.

...nurses give subcutaneous morphine, but if by epidural line, pain doctors continue drugs or if they are not on duty, we have to inform ICU anaesthetics to continue it. But actually here, epidural lines are not effective as ICU anaesthetics are not coming correct at times as they said they have their duties in ICU (Interview 7, Nurse G).

One of the participants explains the current follow-up system of the Pain Clinic. When patients are referred to the Pain Clinic, follow-up care is done by pain doctors. Though they try to do it systematically, patients' co-operation is less because if patients feel better, they do not want to continue the clinic visits.

So follow up pain management is done by our pain doctors in week days but sometimes this is continued if patient is in the ward. After they are discharged, some times they do not come to the pain clinic for follow up. Generally if patient needs to continue pain treatment, our doctors ask to come to clinic though they are discharged from the ward. I think if they haven't pain they do not come to the clinic. But if they have severe pain they come to the clinic or admit to the ward again. This is the current situation (Interview 9, Nurse PC).

Some ward doctors do not like to refer patients to the Pain Clinic due to over sedation of patients. These patients' nutrition status and general hygiene become poor due to drowsiness and sedation effects of some pain drugs. This is also one reason to not refer patients to Pain Clinic. Nurse G was also not satisfied with current practice of Pain Clinic; she explained drug therapy and its influences on patients from Sri Lanka. Nurse G considered Sri Lankan people may not tolerate drugs the same as patients in other countries.

...Some drugs cannot be tolerated by some patients. I think we have to consider our patients: body weight, nutritional status other than comparing other countries' people. Due to lack of proper assessments according to our country people, they felt drowsy or sedated and always try to sleep without taking foods.

...Therefore sometimes ward doctors also hesitate to refer the patients to pain registrars... Those conditions would affect the patients' nutrition and their hygiene as they don't want to eat and even take a shower. I think these things also affect this referral system (Interview 7, Nurse G).

The management of Cancer Hospital does not consider the Pain Clinic a high priority as it only operates on a part-time basis. The consultant comes from National Hospital and the other doctors who do their post graduate training try to cover pain clinic duties. Nurse PC described the unsatisfactory situation of Pain Clinic.

I think we aren't totally satisfied with this current practice. Our pain madam can't do everything by herself. She comes on Saturdays only to conduct the clinic. Pain registrars also work at three weekdays on day times. But pain will occur at any time. It may be at night. So these patients have to be wait till pain registrar comes or Saturday clinic, if they can not be managed in the ward. I think if we have such 24 hours pain service, we can overcome these things.... (Interview 9, Nurse PC).

Doctors control pain management of patients in their wards. Management is with drugs that are given as ordered, by nurses. When a patient requires additional pain management different drugs are used. A part-time Pain Clinic and registrars specialising in pain are available for referral. However, professional issues and a poor team approach mean patients are not referred to this specialised service. Assessment and evaluation of effectiveness of pain regime does not occur. However, terminally ill patients can receive continuous pain management with epidural analgesia. For the majority of patients pain management is ad hoc and not effective.

5.6.3 Patient-related factors

Patients are individuals with traditional, spiritual, cultural and family beliefs about illness and healing. Nurses have many experiences with patients who used traditional healing or relieving methods. Some patients' relations take their relatives home to do some religious or cultural activities. Some patients apply oil and balm to relieve the pain. These are some native treatments. However nurses allow doing these things in the wards if patients want. Nurse D thinks these methods help to relieve pain physically and psychologically. She further gave an example of a patient with multiple myeloma who had unbearable pain.

I have seen many patients use oil, balm or creams for pain. Actually we do not help with these things. If they ask to apply these things I say to do it if they want. I remember one patient asked from me showing "Move" balm, 'Miss, is this good for this arm pain?' then I said 'yes it is, if you want to can apply' she was very satisfied with my answer. Some patients apply Voltaren jelly. They bring these things by themselves and apply, to be get free of pain. ...Sometimes multiple myeloma patients ask to apply these things to reduce their body pain. But we do not say not to do it. If patient can get some relieve either mentally or physically by applying these things, it can also reduce their pain. I think their confidence will reduce their pain. I remember one of my patients had multiple myeloma, she said to me she felt that her pain comes from the bones or in-depth of the muscles. She further said that it was unbearable pain (Interview 6, Nurse D).

The researcher also observed spiritual practices that patients performed in the ward. They have some 'Pirith threads' or other charmed threads and pendants on their neck or hand. These things showed patients followed some cultural and traditional native treatments parallel with western treatments provided in the hospital. Nurses also respect these treatments if they do not affect the other treatments. These traditional practices are their beliefs. Nurse HE also explained those patients' beliefs according to Astrology, Buddhism and the power of meditation.

Most of Sri Lankan people are Buddhists so they do lot of religious activities to get spiritual health like "bodhi-puja", and chanting 'Pirith'. Not only that some people also use traditional charming procedures to get protection from the disease. Our patients also believe in astrology so they consider about auspicious time. They believe their horoscopes....Some patients do some traditional, local treatment parallel to our treatments. I feel all patients try to fight with the disease. We all behave alike with our lives. Therefore there is a trend to respect their religion. Sometime some people change their religion to get more benefits economically and spiritually. Meditation is now popular with these patients. Especially educated persons develop meditation to forget their pain (Interview 10, Nurse HE).

This hospital has recently introduced a counselling unit for psychological support for patients. Children's ward has a separate counsellor. However, these counselling activities do not function well as counselling approaches are new for the hospital staff as well as patients. Doctors have authority to refer the patients to such unit but Nurse D stated that they only refer patients occasionally. She further explained that if nurses have time they would talk with patients as they like to talk with nurses but nurses' practical work situation does not allow this to happen.

I think it was recently started. The referral system is still not functioning properly. However, sometimes our doctors refer the patients to it, but very rarely. I think it will be improved soon. It is also very necessary for patients to get psychological support to relieve their cancer pain. ... We have no leisure time to talk with patient but while we are doing procedures we talk with them very friendly. Sometimes at night some patients come to nurses' station and try start to talk but even at night we can not do it as we have large numbers of patients' tickets to check and update. I felt at many times, patients need to talk with us but the thing is, we haven't time to do it. However, I think these

psychological and spiritual supports are needed for these patients but due to this practical situation, it is a problem (Interview 6, Nurse D).

Nurse H also emphasised the importance of the psychiatrist or psychiatric clinic for psychiatric treatments when necessary. They do not have such a service in this hospital. Even psychologists are very rare in Sri Lanka.

However I feel we need consultant psychiatrist or continuous psychiatry clinic to this hospital. Then we can refer patients and get some psychological treatments if necessary. On the other hand it must be open for everyone as there are many patients and bystanders who are very silently tolerating their psychological stresses. I think this kind of clinic will help to get some kind of psychological support (Interview 8, Nurse H).

Though drug therapy is the main pain management method, the hospital additionally uses some sort of psychotherapy through counselling unit and the health education unit. Health education unit also gives counselling and health education to the patients. They also use music therapy; organize religious activities and recreational activities which help them get some psychological support for the cancer patients as well as their relations. Nurse HE described their activities as:

...We use music therapy to give some relaxation for cancer patients. We use audio system for it. Generally I use music therapy at out-patient department and the clinics in the morning and evening sessions. Most of patients have already appreciated it. I use local and eastern music for it. It is very nice. Apart from that, we use chanting 'Pirith' in the morning as most of our patients are Buddhists. We also organize other religious activities relevant to every religion for giving spiritual health. I think it is also more important to manage cancer pain. When they attend these things they forget their pain. They built confidence to face their life bravely. When considering small children, they have a play house. It is also helpful to forget their pain. Madam arranges army band to sing songs and dancing every fortnight. Sometimes some special dramas, musical shows are arranged by some welfare societies two to three times per year. These are all free of charge. All these things are helped to manage our patients' cancer pain and other psychological stress to some extent (Interview 10, Nurse HE).

Nurses personally realize the importance of psychological, spiritual and cultural approaches to patients' cancer pain management but they have no time to think about it. As well as that, they have no right to refer the patients to the counselling unit.

Doctors are not much concerned about these aspects of patients' well-being therefore most of the time patients try to get psychological and spiritual needs by themselves. Most of cancer patients have good understanding about their disease condition but they have not good understanding of drugs or the treatments. Sometimes patients, therefore refuse drugs even antibiotics and pain killers. If patients feel their pain is controlled or have no pain at all, they refuse to take pain killers. Nurse E described her experiences and she highlighted the importance of patient health education.

*They like to take treatment because they well know their condition. But some patients refuse drugs, especially pain killers. Sometimes they say, "Now I haven't pain so I do not need pain killers."
...Patient education is also important. Some patients can not understand even their disease conditions. Sometimes they refuse antibiotics so we can not give drugs (Interview 2, Nurse E).*

Due to lack of physical as well as human resources, patients are suffering in the hospital in various aspects. Due to shortage of nurses they get minimum attention from nurses. Lack of beds and limited ward environment restricted their freedom and they have to stay on the chairs and on the floor. No room for any recreational activities other than reading and watching television. Nurse A felt this environment also help to increase their pain and body aches. Nurse D emphasized how many patients take their chemotherapy drugs and drips on chairs. She felt very sad about the current situation of cancer patients because the hospital does not provide comfortable facilities for sick patients.

Due to the large number of patients, nurses' workload is high and one nurse has many patients. However, we know most of the patients' situation so we try to give more attention if they want. There are a lot of patients on the floor. At night they have to sleep on the floor. Most of the time if these patients are at home definitely they sleep on the bed but in our hospital they have to sleep on floor. So sometimes they develop backache and other body aches. That is the real situation I feel (Interview 3, Nurse A).

No acceptance here. Actually I think, now you have felt the situation here. We haven't time to do such things. No time to even talk. You see how many floor patients we have. So sometimes we try to give a bed at least giving

chemotherapy but sometimes it is not possible. If we can give a bed for that movement, it is also worth it for them. However, how many patients take their drips on chairs? It is very sad (Interview 6, Nurse D).

Sri Lankan government hospital patients are at medium and low level economical background. Patients from high level economical backgrounds use private hospitals therefore most cancer pain patients in this hospital are not economically wealthy. Most of the time there are the key persons to earn money and look after the kids and family. According to the Sri Lankan culture the family bond is very strong. They always wish to get attention from each other. If patients come from all over the country their relations cannot visit them frequently due to economical and family related barriers. When these people suffer from cancer their psychological pain is high, more than the physical pain. Therefore they need psychological healing methods parallel to drug treatments. This anecdote describes such a situation of the general patients at the hospital.

You know most of the patients' mental status is not so good. Most of them think about their families. Though some patients were very bad, their relations come and see them frequently. But some patients are referred from very rural as well as very remote areas such as Anuradhapura, Polonnaruwa and Abilipitiya. So sometimes their relations cannot come regularly due to long distance or may be their economical backgrounds. Though we give medication for their pain, sometimes we can not assess whether their pain is reduced or not due to their mental status. They always think of their children, how they live...like that... There are big problems that affect these patients when managing pain. All these patients do not come from Colombo area. There are a lot of patients who come from other areas... (Interview 7, Nurse G).

Sri Lankan people have many traditional beliefs that need to be respected by nurses. Even when admitted to the hospital and taking western medicine they need the opportunity to express their beliefs. Nurses try to accommodate patients' needs. Nurse D explain her experiences about beliefs of patients:

Some patients complain about pain at night. Some patients complain pain when cold or it is raining. I don't know why. Sometimes I think these are some misconceptions that they have. Some also think their pain increase on 'poya days' (full moon days). Some patients do not like to take blood at midday time.

If we do, they ask ‘At this time...?’ they express they are unhappy as some people trust bleeding tendency is increased at midday time due to hot weather. These all are their beliefs (Interview 6, Nurse D).

An example is a lack of knowledge of patients who wish to take the same drugs with same colour for pain. If these same drugs come with different colour it may be a problem and patients are not satisfied with new colour. Sometimes some patients require same colour vitamin tablet instead of the different colour original pain drugs to satisfy this belief. Some patients also wish their pain will be reduced as soon as they take tablets. Nurses F and G explained the situation according to their experiences and they think this is psychological.

If we give drugs for pain, some patients start shouting again after taking drugs before the drug action starts. They think when they take drugs, pain should be reduced immediately. So we have to explain to them. Some patients also complain of pain when drugs’ original colours change. They think that is not their routine drugs (Interview 5, Nurse F).

Some of our staff members also tell these things. “This patient pain will reduce even giving ‘B co tablet’”...like that. Therefore some of addicted patients manage by giving them vitamin tablets. However, after taking these tablets they feel pain free. Sometimes it maybe psychological (Interview 7, Nurse G).

The nurses are aware of the need for patients to participate in traditional cultural and spiritual practices. Additionally, patients’ beliefs are accommodated by the nurses to assist in maintaining patients’ mental health. Psychological pain and physical pain are identified by nurses as important.

5.7 Conclusion

This chapter presented analysis of data following Richards handling qualitative data method (2005). The anecdotes of 10 participants, field notes of over 106 hours and reflective notes of the researcher present the ethnography of the current situation of nurses’ cancer pain management in Sri Lanka.

CHAPTER 6

DISCUSSION AND CONCLUSION

6.1 Introduction

The findings of this study identified that the nurse in Sri Lanka is the major category with four sub-categories. Sub-categories influenced the care patients received by nurses at the Cancer Hospital and care provided by nurses. The sub-categories identified are powerless; stuck in an unchanging situation and health care situation in Sri Lanka. All these categories impact on the fourth sub-category which is the current practice of cancer patients' pain management.

This chapter discusses the findings, conclusion, limitations, recommendations and reflections of the researcher on the study. Particular references to the study objectives are addressed in the chapter. That is how nurses practise cancer pain management in a Sri Lankan Cancer Hospital.

6.2 Health care in Sri Lanka

Health care is provided by both public and private sectors in Sri Lanka. Sri Lankan government/public health care system is a free service which provides health care for nearly 60% of the population (Caldwell et al., 1989; Department of Health Services-Sri Lanka, 2003). According to the Department of Health Services, 95% of inpatient care is provided by the public sector through a network of curative care institutions ranging from teaching hospitals to central dispensaries.

The site of this research, the Cancer Hospital, is a teaching hospital under the Ministry of Health. The hospital treats many cancer patients from all over the country.

The limited space of the hospital and the many patients and people in its environment create a chaotic situation. Old buildings present an unplanned image of the hospital. However, a new out-patient department building represents the gradual redevelopment of the hospital. The hospital provides a religious observance area which enables patients to make offerings and as such, reflects the culture and economic circumstances of the country.

Many people use the services at the hospital as it is a well regarded hospital providing a level of care that patients require. There is widespread trust in the technical quality of care delivered by public health care providers in Sri Lanka (Russell, 2005). However, the hospital and the ward environment do not have enough rooms and facilities for the large number of patients that are present (Beck, 2000; Williams et al., 2001). There are many patients in the wards without a bed, called 'floor patients'. They stay on the floor or on chairs with great difficulty. Bystanders who stay with patients are allowed due to a lack of sufficient staff. As such, the hospital is always overcrowded and noisy with large numbers of patients, bystanders and health care workers including doctors, nurses and attendant staff workers in the corridors, ward areas and outdoor areas (Caldwell et al., 1989). This is the situation of health services in a developing country with a large population and economic constraints.

An uncontrolled admission system is the main reason for the overcrowded ward. Not only the hospital wards, most of the clinics are also overcrowded (Perera et al., 2004). Despite the overcrowding, doctors continue to admit patients to the hospital and patients continue to return despite alternative regional hospitals being available. Reputation of the treatment provide popularity of the hospital for cancer treatments and facilities available at the hospital influence patient numbers and doctors' referrals

(Withanachchi & Uchida, 2006). Poor management of patients numbers reflects management system problems in the hospital. An ineffective chemotherapy drug ordering process, poor coordination of patient treatment regimes such as radiotherapy and scans are also problematic and result in extended hospital stays for patients. Most of the public hospitals in Sri Lanka are overcrowded due to several factors (Caldwell et al., 1989). Davis and Walsh (2004) also pointed out the overcrowding is likely to be related to geography and limited resources in developing countries such as Sri Lanka. That is, transport to city centres is readily available and urban residents prefer to use services of specialised hospitals (Wanasinghe, 1995).

Despite large patient numbers, nurse rostering remains unchanged due to the shortage of nurses in the country (Jayasekara & Schultz, 2007). This shortage of nurses and high patient numbers directly influences quality of care and cancer pain management. The nurses have no time to do caring and they give more priority for routine duties. An American study also highlighted that understaffing makes nursing care more task-oriented, giving less time for the human side of patient care (Hart, 2003). However, even the routine duties are often not on time due to the high workload. A lack of timely access to pain medication has been highlighted by a recent study because of nurse workload issues (Sun, Borneman, Piper, Koczywas, & Ferrell, 2008).

Doctors have a major role in the hospital management system because they are the key persons who make decisions (Fernando, 1999). All management positions in the Ministry of Health are held by doctors, including the Secretary. Every ward also has one or two permanent consultant doctors and those consultants manage the patients and sometimes, even the ward. The research identified that the doctors do not work cooperatively resulting in patient management patterns impacting on nursing care. A

study has concluded that cancer pain management that contains integrated processes rather than single tasks or actions improves the management of patients' pain (Brink-Huis, Achterberg, & Schoonhoven, 2008). This is not the current situation at the Cancer Hospital.

As the Sri Lankan health care system including hospital management is strongly influenced by doctors, the issues of shortage of staff and overcrowding in the wards remain unchanged as this system supports doctors' needs. Nurses identified problems with hospital management system especially ward overcrowding, lack of team work and drug administration processes. However, no significant changes have occurred as the nurses' voice is not heard in the administration of the hospital as well as at the Ministry of Health. Nurses are a significant workforce in Sri Lanka yet this study identified they have no control over their work situation or opportunity to make changes to their employment situation.

6.3 The nurse in Sri Lanka

Sri Lankan registered nurses work at public/government hospitals under the Ministry of Health including the Cancer Hospital. They do not have their own professional nursing council. Nurses register under the Medical Council after their three year nursing diploma which is conducted by the Ministry of Health. Nurses do not have any decision making power for their own profession. Sometimes medical professionals make decisions on behalf of nurses by using the power of the Ministry of Health (Cameron, 2001; Fernando, 1999).

Jayasekara and McCutcheon (2006) explored the evolution of nursing services in Sri Lanka and pointed out the nursing profession is delayed in asserting its professional status when compared to other similar countries. Though there are three

Nursing Directors in the Ministry of Health representing nursing education, nursing medical/hospital services and public health services, they are positioned under the Deputy Director General posts held by doctors (Department of Health Services-Sri Lanka, 2003). Nursing education in Sri Lanka is mainly focused on general nursing rather than specialization (Jayasekara & McCutcheon). There is no separate oncology education for nurses, consequently cancer pain management knowledge of nurses is low, as was identified in this study.

The cancer nursing role focuses on many areas including providing support to patient with cancer (Grundy, 2006). The nurse in Sri Lanka also has many roles identified in this study. They provide care to patients by admitting to the ward, administering medications ordered by the doctor, collecting specimens, ordering and handling drugs, coordinating paramedical services as well as supervising junior nurses and assistant staff members. This study identified the role of nurses include a heavy workload directed by other forces such as hospital administration and medical staff. Non-nurse related tasks are specimen taking, ordering drugs, stock maintaining and preparations and many other documentation tasks from admission to discharge of the patients. There are no permanent ward clerks or paramedical services employed in the ward. The nurse is not able to work independently and is completely task-oriented. Sri Lankan nursing practice is still physician driven and treatment focused (Cameron, 2001) as a consequence of medical control of nursing curriculum, hospital management and the lack of professional development of the nurse.

A similar situation to what Size, Soyannwo, and Justins (2007) concluded occur in Sri Lanka. That is, health care facilities are often under staffed and it is not uncommon to have two nursing staff looking after a ward with 50 patients in sub-Saharan Africa. The authors further pointed out many developing countries have a

similar situation. This was evident in this study, with the overcrowding and patients being accommodated on chairs and the floor.

Within the overcrowded task-oriented environment of nursing observed, it is not surprising that pain management is a neglected aspect of nursing care. Studies from other developing countries also cite these barriers to the alleviation of pain in patients (Size et al., 2007; Williams et al., 2001).

The nurses are tired and dissatisfied with rostering and the work but their work situation does not allow them any flexibility. Findings revealed that many of the nurses are doing extra or double duties. However, the nurses are very committed to their work and they do their best. This situation highlights nursing dedication for patient care at the hospital. However, job satisfaction was considered by Cummings et al., (2008) to not be enough to maintain and build an oncology nursing workforce if nurses continue to experience such burnout from workload demands. For nurses observed in this study, surviving the shift was all they could manage without additional tasks. Attendances at in-service lectures by nurses were spasmodic as has been identified in this study.

Findings of the study highlighted problems for nurses with the toxicity of drugs they reconstitute. Allergic reactions are common. The researcher observed chemotherapy drug preparation precautions are available such as goggles, masks and gowns however; the nurses do not use them properly. These protective pieces of equipment were also observed not to be of good quality. Occupational health and safety areas were therefore not considered by hospital management as important to supervise and enforce safe practices. Kosgeroglu, Ayranci, Ozerdogan, and Demirustu (2006) found a similar situation in Turkey. Due to the rush to finish the tasks, the nurses do not care about these precautions as they feel uncomfortable with goggles

and gowns. Nurses were generally aware of the measures required for protecting the environment and themselves, but they did not apply them in practice (Kosgeroglu et al.). Although many safety provisions were advanced to reduce workers' exposure in the 1980s, recent studies have shown that workers continue to be exposed to these drugs despite safety policy improvements (Connor & McDiarmid, 2006). A lack of regard by hospital management for the health and welfare of the important nurse workforce is evident in this study.

The nurses perform duties as required by hospital management and ward doctors. However, they put their health at risk by an excessive workload, increased work hours and poor occupational health and safety practices in the preparation of toxic chemotherapy drugs. It is not known if this is the situation throughout Sri Lanka for government employee nurses. However, the literature documents the situation of nurses in developing countries being exploited and overworked (Martin, 1998; Size et al., 2007).

6.4 Cancer pain knowledge and attitudes among nurses

Many findings of this study are consistent with the findings of other studies regarding deficits in nurses' knowledge and attitudes regarding pain management (Clarke et al., 1996; Ferrell et al., 1991; Matthews & Malcolm, 2007; McCaffery & Ferrel, 1997). The problem of nursing education in Sri Lanka was also highlighted by Williams et al., (2001), who established a cancer pain clinic in Sri Lanka in 1999. The introduction of the pain clinic provided training of health care workers including nurses. However this study identified that nurses' knowledge and attitudes regarding cancer pain management still remains a problem. There are multiple explanations identified why poor cancer pain management occurs. These include a clear deficit in

nurses' knowledge and attitudes in pain management related to inadequate education, inaccurate knowledge of cancer-related pharmacology and poor cancer patient assessment skills. These factors are also identified by many studies not only in developing countries, but also in developed countries (Howell et al., 2000; Matthews & Malcolm, 2007; McMillan et al., 2000; Rushton et al., 2003; Tafas et al., 2002; Vallerand et al., 2007; Young et al., 2006).

General nurses are employed at the Cancer Hospital as registered nurses. At the beginning, they do not have enough knowledge about cancer pain management because of inadequate pain management modules in their three years nursing curriculum. This is the most common explanation, that nurses receive too little pain management education identified previously by many authors and studies (Ferrel et al., 2000; McCaffery & Ferrell, 1995; McCaffery, 2000; McMillan et al., 2000). However, some introductory oncology and pain management in-service programmes are conducted by the Cancer Hospital during orientation. Despite regular in-service education on pain management, it can be concluded that these theoretical pain management lectures do not have enough impact to change the situation. For nurses overburdened with work, it is not surprising that no effort is instituted to make changes that reduce their workload.

Due to a lack of relevant education, nurses practice by getting knowledge and developing attitudes by modelling their senior nurses' approaches. New nurses imitate senior nurses in the ward and acquire cancer nursing practice. This situation does not enable nurses to get much new knowledge and they continue to practice within the usual routine pattern demonstrated by their seniors. These findings are also consistent with other studies on nursing practice patterns even in western/developed countries

(Bernardi et al., 2007; McMillan et al., 2000; Rushton et al., 2003; Williams et al., 2001).

A lack of specialization in areas of nursing practice is common in developing countries. The consequence of this is that nurses do not acquire specialized knowledge such as cancer pain management in oncology nursing. Specialization is expensive as nurses need to study, are removed from the workforce to study and then tend to practice in one area of nursing. This process is often too expensive for a developing country to initiate as has been described previously (Murray, Grant, Grant, & Kendall, 2003; Shuriquie, While, & Fitzpatrick, 2007). Efforts to establish a breast clinic nurse positions were previously thwarted in Sri Lanka because of the shortage of the staff and the attitude that nurses should be multi-skilled and able to be transferred throughout departments as required (Perera et al., 2004). It is evident that there is not even specialized separate nurse for the Pain Clinic.

Nursing in Sri Lanka is controlled by the medical profession with the consequence that nurses do not acquire a professional esteem that is common amongst nurses in developing countries (Cameron, 2001). The nurses in this study were oppressed by medical profession as they were registered by the Medical Council. Medical profession is happy to maintain the situation as it serves doctors' needs. However, for nurses, it does not allow career development, autonomy of practice and the initiation of nursing specialized areas of practice. Such initiatives would benefit patients with the enhanced nursing knowledge leading to quality patient care (Shuriquie et al., 2007).

Nurses' knowledge deficits and a lack of self esteem and power to change practice were revealed as findings of the study. Mostly, the nurses copied senior nurses' practice as they had received no formal oncology nursing and minimal cancer pain

management education. Because of this, nurses practise oncology nursing with minimum knowledge and always under medical direction. These factors collectively create a nurse attitude of powerlessness and oppression.

6.5 Nurse cancer pain management practices

Cancer pain management practices of nurses are influenced by the situation that they work in. Lack of knowledge and attitudes about cancer pain management keep nurses in an unchanging situation as has been identified in other studies (McCaffery & Ferrel, 1997; Tsai, Tsai, Chien, & Lin, 2007).

Many different beliefs about cancer pain were put forward by the participants. Nurses believe cancer pain has physiological as well as psychological effects. Physical aspects of pain relate to treatments and effects of the cancer growing and spreading throughout the body. Psychological effects are fear, as a diagnosis of cancer is in a country with minimal resources to treat the condition often means death.

The nurses believed that patients should not tolerate severe pain as it influenced their quality of life. USA nurses also believed that pain can and should be effectively managed (Vallerand et al., 2004). Despite the nurses believing that patients should not tolerate pain, little was done by the nurses to provide psychological support to patients. The workload of the nurses and lack of autonomy of practice created this environment. Additionally, palliative care of terminally ill patients was not available. Further development of the cancer nurse role would clearly address this deficit in patient care.

The current cancer pain practice gives priority for drug therapy ordered by doctors. However, if patients do not respond to drugs, they may be referred to the Pain Registrar or Pain Clinic. Within this situation, nurses have no right to give any

medication without the written order from the doctor (Lui, So, & Fong, 2008; Williams et al., 2001) therefore nurses' cancer pain management is to follow the doctor's orders. Due to this situation, cancer pain management is not a separate practice but is included in the routine nursing tasks related to medication procedures, as was identified in this study.

The current system of cancer pain management in this ward identified that the nurses do not consider the patient as an individual person. They are considered under the label of 'patients'. Some nurses have been reported as thinking patients are shouting unnecessarily, as they have already received pain killers (Hiscock & Kadawatage, 1999). Nurses do not understand the concept that 'pain is highly individual'. This nursing behaviour highlighted Sri Lankan nurses' knowledge and attitudes to cancer patients as well as current practice of cancer pain management. The situation is similar to many developing countries where nurses have minimal education in cancer nursing (Davis & Walsh, 2004; H.-D. Yu & Petrini, 2007).

Though all nurses felt that severe cancer pain must be relieved (Vallerand et al., 2004), they do not use any acceptable pain assessment techniques or methods. It was surprising that most of the nurses have no knowledge of pain assessment tools. Layman et al., (2006) identified a similar situation in the USA. The authors identified negative beliefs about the use of pain assessment tools by nurses. Nurses in this setting assessed patient's pain levels through their experiences. Nurses considered they can interpret patients' pain through actions such as screaming, shouting and verbal requests for pain medication then they refer to doctors for pain medication order. Within the current practice, not only the nurses but also ward doctors do not assess pain by using pain tools. This has also been identified as a problem by a group of researchers in 2001 (Yu, Wang, Cheng, Yang, & Cleeland, 2001).

This study found that nurses are not directly involved in managing patients' cancer pain. Additionally, nurses and doctors do not use any acceptable tool to assess pain. Without proper assessment, pain medication for patients is given following doctors instructions. Most of the nurses think cancer pain is unbearable and it should be relieved but they do not implement any practices to resolve the pain except referral to doctors for drug therapy. Drug therapy is the most common pain management approach used in this setting. Interestingly, drug therapy for pain is not individualised as it evolves into routine work tasks and is mostly administered during medication rounds.

6.6 The barriers to nurse cancer pain management

Though a number of guidelines for effective pain relief has been published internationally, there are still patient and staff related barriers to successful pain management not only in Sri Lanka, but also globally (Bostrom et al., 2004).

The findings of this study revealed many barriers to cancer pain management. Patient, doctor and nurse-related factors influence cancer pain management. Lack of resources also act as a main barrier (Beck, 2000). As a developing country, Sri Lanka has only one Cancer Hospital which has limited facilities. There are not enough pieces of equipment and technology to service the large number of patients requiring care. A recent study also concluded that the resources of the public hospitals in Sri Lanka are not enough for quality services for patients (Withanachchi, Uchida, Nanayakkara, Samaranayake, & Okitsu, 2007).

The large number of patients creates a chaotic environment in the ward as well as the hospital. Shortage of nurses is another barrier to cancer pain management (Beck, 2000). The study findings concurred with Martin (1998), who reviewed literature

regarding cancer in developing countries and pointed out oncology wards often have only one registered nurse per 20 beds. Patients' needs are therefore fulfilled by relatives or friends who are expected to feed the patients and sleep near or under the bed.

Nurse barriers include a task oriented nursing approach operating in the ward. Completing tasks is what is required, with no time for individual patient needs to be addressed. This is the system that nurses learn and they maintain such a system as was found in this study.

Communication with physicians and nurse-physician relationships were also seen as barriers in the literature (Beck, 2000; Vallerand et al., 2004). This occurs in Sri Lanka with nurses not being supported by doctors in the management of patients' pain, as nurses are not allowed to initiate any patient medication without doctor's order (Williams et al., 2001).

Ineffective communication and poor care giving because of a lack of teamwork and professional relationships is evident from the findings of the study. Unfortunately, teamwork does not exist in all hospital settings in most developing countries including Sri Lanka and professional boundary issues interfere with effective care giving (Beck, 2000). Mistrust and non-professional attitudes are common among the health professionals in Sri Lanka. Beck pointed out there has been little discussion about mistrust and non-professional attitudes within the cancer pain management literature. This important area therefore requires additional research.

One of the main barriers to effective cancer pain management is lack of knowledge as well as attitudes of health care professionals (Lui et al., 2008). The findings of this study emphasized health care workers, mainly nurses and doctors, need more knowledge and changes in attitudes regarding cancer pain management. Beck (2000)

also support this situation regarding knowledge and change of attitudes for health care workers caring for cancer patients. This was highlighted in multiple ways including ignorance of pain, need for pain education and a lack of knowledge regarding pain assessment tools.

The other main barrier is the lack of an accessible pain management team. Findings of the study identified that the Cancer Hospital has not even a permanent pain consultant. Madam, who is the anaesthetic consultant, handles the Pain Clinic by herself. She is not attached to the hospital and comes from the National Hospital of Colombo for a Saturday morning clinic. Pain Registrars are also not permanent doctors as they are post graduate students who come for short periods. However, the Pain Clinic attempts to give service as much as possible. However, the Cancer Pain Clinic and its services are not widely accepted among the consultants and the ward doctors therefore Pain Clinic is not widely utilised within the hospital. This current situation strongly influences the practice of cancer pain management. That is, effective cancer pain management is not strongly supported within the hospital.

Both nurses' and patients' misconceptions also act as barriers to effective cancer pain management (Lui et al., 2008). Patients have misconceptions and traditional beliefs that affect their treatment. Nurses also have many malpractices related to cancer pain management. Some of these are related to knowledge and attitudes to cancer pain management such as poor knowledge of break-through pain and addiction concerns. This is a finding that has also been identified by other authors (McCaffery & Ferrel, 1997; Vallerand et al., 2004).

The recent study of barriers to pain assessment and management in cancer by Sun et al. (2008) concluded that patient, professional and system-related barriers influence optimal pain relief. This is definitely the situation in Sri Lanka, where there are no

institutional guidelines or policies to guide pain management (Beck, 2000). Pain management is therefore a neglected entity in cancer nursing and practice in this ward.

6.7 Therapeutic and non-therapeutic cultural pain management therapies for cancer patients.

Sri Lankan traditional people have strong traditional beliefs. Their religious background influences many of the beliefs which they bring to the hospital when admitted.

As the Cancer Hospital practices western medicine, nurses do not promote any native treatment within the hospital. However, sometimes it was found that patients apply oil, balm to relieve pain. Sometimes after discharge, patients acknowledged to nurses that they seek native traditional healing treatments. Though nurses do not promote such tasks in this hospital, they allow traditional healing methods if it is not harmful to the current treatments. Vickers and Cassileth (2001) reviewed unconventional therapies for cancer and cancer-related symptoms. The authors concluded that the helpfulness of components of complementary and alternative medicine is acknowledged and should be allowed, providing they are not harmful to patients.

Nurses have many experiences with patients who use traditional healing or relieving methods. Cancer patients often seek complementary and alternative medicine approaches for the relief of disease-related symptoms as well as reduction of treatment side effects (Mansky & Wallerstedt, 2006). Nurses identified that some patients' relations take the patient home to undertake religious or cultural healing

activities. The findings of the study revealed that these methods are believed by nurses to help relieve patients' pain either physically or psychologically. The integration of touch therapies, mind-body therapies and other religious or cultural complementary therapies for cancer patient care is warranted (Deng & Cassileth, 2005) although this does not occur in the ward studied.

The study also identified the need for spiritual aspects of care for some patients. "Pirith threads" or other charmed threads are worn on their neck or hand. Additionally, patients have many beliefs according to Astrology, Buddhism and the power of meditation. A recent study finding concluded that meditation helps to improve psychological strength, leading to improvement in severe pain (Lafferty, Downey, McCarty, Standish, & Patrick, 2006). Hospital management maintains a place to worship Lord Buddha because most of the patients are Buddhists. They also broadcast Buddha's Words such as 'Pirith' every morning and on special occasions. Priests also give blessings to patients if they are required.

Therapeutic and non-therapeutic cultural pain management practices occur. The practices are acknowledged by the nurses as benefitting the patients' psychological health and spiritual well being so are freely allowed in the ward. A strong influence of Buddhism pervades the hospital, which is beneficial to patients and relatives.

6.8 Limitations of the study

The results of this study can not be generalized to all hospitals in Sri Lanka since data was only gathered from one hospital. It is also limited to one ward of the Cancer Hospital. However, the results provide insights into the current nursing practice towards cancer pain management at the Cancer Hospital.

A further limitation is that this is a small study with a limited time frame. Time was limited in the field because of the time limit of Master's study.

Due to a lack of a research culture in nursing in Sri Lanka, some participants were reluctant to explore important matters related to their practice. The interviews were very new for some of them to be involved in. Some informants took part for the first time in a research study in their nursing career.

The researcher undertook the study in English, not his mother tongue. Many of the quotes of participants presented are grammatically awkward partly due to translation into English by the researcher. The thoughts and the feelings of the participants are sufficiently well articulated to provide the meaning of their experiences.

The researcher's previous experiences as a nurse in Sri Lanka may have influenced the study design and data gathering. However, the researcher had not been involved in cancer nursing and this provided the researcher with the ability to explore cancer pain management and practices among nurses.

Another limitation was that as a novice researcher, the researcher was learning along the way during the data collection and analysis period. The supervisors of the research kept challenging the role of the researcher and providing direction for the study.

6.9 Conclusion

This study explored nurses' cancer pain management practice in Sri Lanka. Patients are suffering pain because of a lack of knowledge about effective pain management approaches not only among the nurses, but also among doctors. Areas for improvement have been identified with the overall aim of enhancing nurses' cancer pain management practice.

The study findings further illustrate that Sri Lankan nurses provide poor patient cancer pain management because of a lack of resources, large number of patients, shortage of nurses and heavy workload in this hospital setting. Medical management is also not focused on cancer pain management. This situation directly influences nursing practice because nurses carry out doctors' orders.

Overall, change is required in hospital administration to reduce nurses' workload, increase nursing staff and increase education on pain management. Without these changes, cancer patients will continue to experience pain. Additionally, nurses will continue to be poorly educated on pain management and be unable to provide adequate pain relief for patients.

The professional status of the nurse in Sri Lanka requires consideration to develop a more equitable health system where all staff are afforded the recognition of the work they are doing. A professional nurse can contribute enhanced practice to a health system that will benefit patients, nurses and the system.

6.10 Recommendations

Recommendations, based on the findings of this study are that:

- It is important to bring the nursing standard of patient pain management to a higher level. Nurses therefore need sound education to develop their knowledge, skills and attitudes towards cancer pain management. This mode of education should be English medium and focused on usage of the Internet for current information.
- Changes to nursing curriculum are recommended to include enough oncology and cancer pain management content for better practice.

- Specialization in oncology nursing should be considered with curriculum development.
- Ensure pain management education is given to other health care workers especially doctors, to improve practice.
- It is important to develop a 24-hour separate pain management team or unit in the hospital to relieve patients' pain.
- Ministry of Health should accept the importance of palliative care services as well as pain management services. The implementation of appropriate policies, palliative care and pain management at hospital level of practice are recommended.
- Further research is needed in this important area of cancer pain management especially from patients' perspectives.

MY REFLECTIVE DIARY

As I start to write my reflections of the two years' journey of research as a student, I feel a sense of relaxation at the dawn of ending the hardest studentship in my life as an International student in Australia. However I know as a university lecturer, this is the beginning of my academic career.

Being a foreign student and coming from non-English speaking developing country, the beginning of my studentship was hard. It was worse due to the separation from my kids and family environment. This was the first time I was away for a long time from my home country therefore I also felt home sick badly at the beginning. However I had determination, if I have started something, I have to come to the end of it therefore I worked hard till my Master of Nursing by research journey came to the end. Now I am so happy.

However, I went through my past two years of studies, I faced different situations at different times. Sometimes I struggled with English language and sometimes research process as a novice researcher. Actually I am fortunate to get good supervisors who understand the situation and give their guidance when necessary, all the time. With their valuable directions I dedicated two years of my life for genuine research study which was related to my country.

Though sometimes I struggled with doing research activities, sometimes it was very exciting. Dedication of hours and hours, rewriting pages and pages according to my supervisors' guidance and final result of writing up the thesis remain the satisfaction of the effort of the two years.

Within these two years, I have studied many things. Some of them are very important to my academic career. Some of them are also important to my personal life. I studied many things related to scientific research including research methods,

research theories and different research approaches which built confidence to do future research. On the other hand I have had valuable experiences in the field of education, health system as well as socio-cultural background in Australia. Even though I will leave Australia, these academic and social values will remain permanently in my mind and I can apply them when necessary, according to the situations in Sri Lanka.

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APPENDICES

APPENDIX 1: ACU HREC Approval

Australian Catholic University
Brisbane Sydney Canberra Ballarat Melbourne



Human Research Ethics Committee

Committee Approval Form

Principal Investigator/Supervisor: Dr Michelle Campbell Melbourne Campus
Co-Investigators: Dr Colleen Rolls Melbourne Campus
Student Researcher: Badurakada Sunil Santha De Silva Melbourne Campus

Ethics approval has been granted for the following project:
An exploration of the views of nurses in cancer pain management in Sri Lanka.
for the period: 15 September 2007 to 15 January 2008
Human Research Ethics Committee (HREC) Register Number: V200708 1

The following standard conditions as stipulated in the *National Statement on Ethical Conduct in Research Involving Humans (1999)* apply:

- (i) that Principal Investigators / Supervisors provide, on the form supplied by the Human Research Ethics Committee, annual reports on matters such as:
 - security of records
 - compliance with approved consent procedures and documentation
 - compliance with special conditions, and
- (ii) that researchers report to the HREC immediately any matter that might affect the ethical acceptability of the protocol, such as:
 - proposed changes to the protocol
 - unforeseen circumstances or events
 - adverse effects on participants

The HREC will conduct an audit each year of all projects deemed to be of more than low risk. There will also be random audits of a sample of projects considered to be of negligible risk and low risk on all campuses each year.

Within one month of the conclusion of the project, researchers are required to complete a *Final Report Form* and submit it to the local Research Services Officer.

If the project continues for more than one year, researchers are required to complete an *Annual Progress Report Form* and submit it to the local Research Services Officer within one month of the anniversary date of the ethics approval.

Signed: *Jay Hayduk* Date: *24/8/07*
(Research Services Officer, Melbourne Campus)

APPENDIX 2: Cancer Hospital Director's Approvals



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CANCER HOSPITAL (TEACHING)
MAHARAGAMA

දුරකථන අංක } 2850252/3
Telephone: } 2842052
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Fax: } 2840233
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Your Ref: }
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My Ref: }

පිළිකා රෝහල (ශික්ෂණ)
මහරගම.
ශ්‍රී ලංකාව.
Cancer Hospital (Teaching)
Maharagama,
Sri Lanka.
දිනය }
Date }

17th August, 2007

The Principal Supervisor,
The Australian Catholic University (ACU),
Melbourne.
Australia.

Dear Madam,

Permission to Conduct Research on Cancer Pain Management

This serves to state that permission has been granted to Mr. B.S.S. De Silva presently attached to your institution as a research student, to conduct a research study on cancer pain management at the Cancer Hospital, Maharagama, Sri Lanka.

In this context, he is permitted to collect the necessary data from relevant nurses and related health care workers in this hospital.

Yours faithfully,

Dr. Kanishka Karunaratne.
MBBS. MS. FRCS(ED). FRCOG(UK).
DIRECTOR,
National Cancer Institute,
Maharagama,
Sri Lanka.

Dr KANISHKA KARUNARATHNE
MBBS.MS FRCS(ED) FRCOG,
Director
Cancer Hospital (Teaching)
Maharagama.

Copy to: A.O.(fip)

DrKK/dm

B.S.S.De Silva,
No; 557/2,
Mampe North,
Piliyandala.
Sri Lanka.

04th April 2006.

The Director,
Cancer Institute,
Maharagama.

Dear Sir/Madam,

Re: Request of Approval of permission to participate nurses for a research

I the undersigned Badurakada Sunil Santha De Silva, doing higher studies in Australia. I am following Master of Nursing by research degree at Australian Catholic University (ACU) in Melbourne.

Currently I attached to Open University of Sri Lanka (OUSL) as a lecturer (Probationary) at the Department of Health Sciences. As a lecturer I have to continue my higher education for the benefit of myself as well as the improvements of health services in Sri Lanka.

My research topic is *An Exploration of the views of Nurses in Pain Management in Sri Lanka*. I plan to do qualitative study. Therefore I wish to collect data from 06 to 10 nurses at CIM using the method of interview. Please be kind enough to give permission to participate them for my study. I attached my research proposal with this letter.

Thank You,

Yours Faithfully.



B.S.S.De Silva.

Permissiya ganta



Dr KANISHKA KARUNARATHNE
MBBS.MS FRCS(ED) FRCOG,
Director
Cancer Hospital (Teaching)
Maharagama.

APPENDIX 3: Sri Lanka Medical Association HREC Approval



SLMA SRI LANKA MEDICAL ASSOCIATION
6, WIJERAMA MAWATHA, COLOMBO 7, SRI LANKA T'phone: 2693324 Fax: 2698802

28 January 2008

Mr B Sunil S De Silva,
557/2, Mampe North,
Piliyandala

Dear Mr de Silva

ERC/07-017: An Exploration of views of Nurses in Cancer Pain Management in Sri Lanka

I apologise for the delay in writing to you.

The Ethical Review Committee which met on 30 November 2007 gave approval for the above study.

Yours sincerely

A handwritten signature in blue ink, appearing to read 'Anoja Fernando'.

Prof Anoja Fernando
Chairperson
Ethical Review Committee

APPENDIX 4: Recruitment Advertisement

NOTICE



CANCER HOSPITAL (TEACHING)
MAHRAGAMA,
SRI LANKA.



Australian Catholic University Limited
ABN 15 050 192 660
Melbourne Campus (St Patrick's)
115 Victoria Parade Fitzroy VIC 3065
Locked Bag 4115 Fitzroy MDC VIC 3065
Telephone 613 9953 3000
Facsimile 613 9953 3005
www.acu.edu.au

Invite to take part in this research study on.....

An Exploration of Nurse's Cancer Pain Management in Sri Lanka

As the numbers of patients are suffering from cancer pain it is imperative that nurses are able to understand the cancer pain and the needs of this special group of patients.

You are invited to take part in a research project that aims to explore the nurse's cancer pain management. With your help, this study will observe practicing nurses in the medical oncology ward in normal everyday practice when caring for patients with cancer pain.

Who can participate?

Any nurse who has at least two years experiences in this ward/hospital.

Your participation will help to:

Improve nursing pain management for cancer patients and nursing curriculum developments.

What you will need to do?

Get the information letters from your ward sister and read: Inform your willingness to your ward sister; fill the consent form and handover to her. Interviews can be conducted pre-negotiated place as your wish. Simply carry out your normal everyday practice when caring for patient.
Your identity will not be disclosed.

Who is the researcher?

Sunil De Silva - currently undertaking Master of Nursing (Research) at Australian Catholic University in Australia. For more information call 0715602040.

When and where?

The research will take place from the 17th October 2007 onwards...at your ward premises.

APPENDIX 5: Information Letter

Australian Catholic University
Brisbane Sydney Canberra Ballarat Melbourne



Australian Catholic University Limited
ABN 15 050 192 660
Melbourne Campus (St Patrick's)
115 Victoria Parade Fitzroy VIC 3065
Locked Bag 4115 Fitzroy MDC VIC 3065
Telephone 613 9953 3000
Facsimile 613 9953 3005
www.acu.edu.au

INFORMATION LETTER

TITLE OF PROJECT: An Exploration of the Views of Nurses in Cancer Pain Management in Sri Lanka.

NAME OF PRINCIPAL INVESTIGATOR: Dr. Michelle Campbell.

NAME OF STUDENT RESEARCHER: B.Sunil S. De Silva.

PROGRAMME IN WHICH ENROLLED: Master of Nursing (Agency for Health Care Policy and Research [AHCP&R])

Dear Participant,

You are invited to participate in a research project exploring nurse cancer pain management in Sri Lanka.

Knowledge about nurse cancer pain management in Sri Lanka is limited. This study may help contribute to nurse education and the development of guidelines for management of cancer patients who are suffering from pain. This could ultimately improve quality of life, nursing knowledge and education, and reduce occurrences of mismanagement of pain in this vulnerable patient group. Finally results could ensure registered nurses are better informed and aware of the appropriate standards of caring for patients with cancer.

There are no anticipated risks beyond normal day-to-day living associated with your participation in this project. If you are distressed by participating you may contact Dr.H.L.R.N Ranwala, Consultant at Pain clinic for counselling (Tel. no: 01128502520 ex 451).

The project will involve a one hour audio taped interview where you will be asked about the pain management that relate to patient care as well as some questions about you such as your age, qualifications and years of nursing experiences. You may refuse to answer any question. Additionally participation may involve observation of your practice caring for cancer patients in the ward at Cancer Institute, Maharagama, Sri Lanka. Participation observation will include observing nurses caring for cancer patients over a period of one month for 3-4 hours each day.

Your participation is voluntary and you can choose not to participate or to withdraw from participation at any time during the project without having to neither give a reason nor justify that decision. It will not effect your employment in any aspect.

All the face to face interviews can be conducted in a pre negotiated place on a date and time of your choice after working hours. The pain clinic office or nurse managers' room may be used.

All information will be kept confidential. All identifying information will be removed from the written transcripts and code number used. Any reports of this research will not identify you or anyone whose name you mention. A thesis will be written from this research.

Any questions regarding this project should be directed to the Principal Investigator or the Student Researcher.

<u>Principal Investigator</u>	<u>Second Investigator</u>	<u>Student Researcher</u>
Dr Michelle Campbell, Head, School of Nursing (VIC) Australian Catholic University Melbourne Campus Locked Bag 4115 FITZROY VIC 3065 Tel: 0061 3 9953 3184 Fax: 0061 3 9953 3385	Dr Colleen Rolls, Lecturer, School of Nursing (VIC) Australian Catholic University Melbourne Campus Locked Bag 4115 FITZROY VIC 3065 Tel: 0061 3 9953 3191 Fax: 0061 3 9953 3355	B.Sunil S. De Silva. MSc Candidate, School of Nursing (VIC), Australian Catholic University Melbourne Campus Locked Bag 4115 FITZROY VIC 3065 Tel: 061 422082227

The researcher wishes to provide appropriate feedback to participants on the results of the project.

This study has been approved by the Human Research Ethics Committee at Australian Catholic University.

In the event that you have any complaint or concern about the way you have been treated during the study, or if you have any query that the Investigator or Supervisor and Student Researcher has not been able to satisfy, you may write to the Chair of the Human Research Ethics Committee care of the nearest branch of the Research Services Unit.

VIC: Chair, HREC
C/o Research Services
Australian Catholic University
Melbourne Campus
Locked Bag 4115
FITZROY VIC 3065
Tel: 00613 9953 3158
Fax: 00613 9953 3315

Any complaint or concern will be treated in confidence and fully investigated. The participant will be informed of the outcome.

If you agree to participate in this project, you should sign both copies of the Consent Form, retain one copy for your records and return the other copy to the Principal Investigator/Supervisor or Student Researcher.

.....
Principal Investigator/Supervisor

.....
Student Researcher

APPENDIX 6: Consent Forms

Australian Catholic University
Brisbane Sydney Canberra Ballarat Melbourne



Australian Catholic University Limited
ABN 15 050 192 660
Melbourne Campus (St Patrick's)
115 Victoria Parade Fitzroy VIC 3065
Locked Bag 4115 Fitzroy MDC VIC 3065
Telephone 613 9953 3000
Facsimile 613 9953 3005
www.acu.edu.au

CONSENT FORM

Copy for Participant

TITLE OF PROJECT: An Exploration of the Views of Nurses in Cancer Pain Management in Sri Lanka

NAME OF PRINCIPAL INVESTIGATOR: Dr. Michelle Campbell.

NAME OF STUDENT RESEARCHER: B. Sunil S. De Silva.

I..... *(the participant)* have read *and* understood the information provided in the Letter to Participants. Any questions I have asked have been answered to my satisfaction.

(Please indicate your choice either one or two options)

I agree to participate in a one hour audio-taped interview.

I agree to observation of my practice and for field notes to be written about my practice knowing that my identity will not be disclosed in the field notes.

I realise that I can withdraw or refuse my consent at any time without any comment or penalty and it will not effect my employment. I agree that research data collected for the study may be published or may be provided to other researchers in a form that does not identify me in any way.

NAME OF PARTICIPANT...
(block letters)

SIGNATURE DATE

SIGNATURE OF PRINCIPAL INVESTIGATOR:.....

DATE:.....

SIGNATURE OF STUDENT RESEARCHER:.....

DATE.....

CRICOS registered
provider:
00004G, 00112C, 00873F,
00885B

CONSENT FORM
Copy for Researcher

TITLE OF PROJECT: An Exploration of the Views of Nurses in Cancer Pain Management in Sri Lanka

NAME OF PRINCIPAL INVESTIGATOR: Dr. Michelle Campbell.

NAME OF STUDENT RESEARCHER: B. Sunil S. De Silva.

I..... (the participant) have read and understood the information provided in the Letter to Participants. Any questions I have asked have been answered to my satisfaction.

(Please indicate your choice either one or two options)

I agree to participate in a one hour audio-taped interview.

I agree to observation of my practice and for field notes to be written about my practice knowing that my identity will not be disclosed in the field notes.

I realise that I can withdraw or refuse my consent at any time without any comment or penalty and it will not effect my employment. I agree that research data collected for the study may be published or may be provided to other researchers in a form that does not identify me in any way.

NAME OF PARTICIPANT:.....
(Block letters)

SIGNATURE..... DATE.....

SIGNATURE OF PRINCIPAL INVESTIGATOR:.....

DATE:.....

SIGNATURE OF STUDENT RESEARCHER:.....

DATE.....

CRICOS registered
provider:
00004G, 00112C, 00873F,
00885B

APPENDIX 7: Participant Observation Theme List

Participant Observation Theme List

Nurses who work in Cancer Institute will be observed using non participant observation. a ward will be selected and the researcher will spend two hours time in morning and two hours time in the afternoon for at least one month time period, focusing on cancer nurse pain management. Areas to be observed include:

- Nursing duty allocation.
- Nurses' routings and the role according to their working environment.
- Nurse patient relationship.
 - caring
 - therapeutic
 - tasks
- Nurse responses for patient complaints of pain.
- Nurse responses for break through pain.
- Pain relieving drugs handling.
- Psychological approaches for pain management.
- Tools for pain assessment.
- Nurse current pain management practices.
- Barriers that affect nurse management cancer pain.
- Observe nursing duties and time management.

APPENDIX 8: An Interview Theme List

An Interview Theme List

Intended topic areas for discussion in an interview;

- Demographics questions including age, nursing qualifications and years of experiences.
- Educational backgrounds: cancer pain management.
 - Can you tell me about your education preparation to provide pain management for cancer patients?
- Personal views of cancer pain
 - What do you think about cancer pain?
 - Do you think patients are suffering from cancer pain in this hospital?
- Current practices of cancer pain management.
 - What is the general nursing practice for cancer pain management that you use?
 - What do you think about these practices?
- Pain relieving strategies.
 - What kind of strategies do you use to relieve cancer pain in patients?
- Pain assessment tools.
 - Do you use a pain assessment tool?
 - What kind of tools do you use?
 - Can you tell me about your use of pain assessment tools?
- Do hospital finances management/doctors influence your management of cancer pain?

- Do you use any psychological pain management approaches such as massage, spiritual care?
- Multidisciplinary team work influences.
- The views of malpractices and misconceptions regarding cancer pain management.
- Barriers that affect cancer pain management at the hospital.