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"I take it you're anti-drugs are you? Well dinnae treat me like a piece of shit" A grounded theory of the pain management of drug users in acute care settings

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RESEARCH REPORT TO FUNDERS

**“I take it you’re anti-drugs are you? Well dinnae treat me like a piece of shit”
A grounded theory of the pain management of drug users in acute care settings**

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Research report to funders February 2009:
Pain management in drug users in the acute care setting

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Research report to funders February 2009:
Pain management in drug users in the acute care setting

EXECUTIVE SUMMARY

- Drug users present unique challenges in acute care settings with pain management noted to be at best sub-optimal, at worst non-existent.
- Other factors such as knowledge, fears and opioid induced hyperalgesia (OIH) may also compromise therapeutic effectiveness.
- Red flag behaviours have not been validated and may be relatively indistinguishable with drug seeking behaviour, pseudo addiction or other 'aberrant' behaviours.
- This study reviewed the perceptions and strategies of drug users and nurses with regard to pain management in the acute care setting
- 11 drug users were interviewed (9 in the acute care setting). Five focus groups (n=22) involving nurses and recovering drug users with varying degrees of knowledge and experience of the phenomenon under study were undertaken in their respective settings (acute care, pain, community addictions, recovering drug users, infectious diseases).
- A constructivist grounded theory approach was applied. A constant comparative method of data collection and analysis was undertaken and a coding paradigm interrogated data.
- The theory contends that nurses and drug users struggle with moral relativism and their respective routines and rituals in managing pain in the acute care setting. Moral relativism both represents the phenomenon and explains the basic social process.

- Drug users lay claim to expectations of compassionate care and moralise via narration. Paradoxically nurses reported the caring ideal and the mutuality of caring was diminished and thus their therapeutic effectiveness was compromised.
- Drug users and nurses struggled to authenticate pain and did so against the backdrop of sensitivities and stigma. Knowledge, fears and the extent to which nurses may be able to curtail aberrant behaviour mediated the 'social' tolerance of the drug user in the acute care setting.
- Physiological tolerance was obscured by limited understandings of OIH and pseudoaddiction. Consequently, both protagonists displayed aberrant behaviours. Those behaviours may have different meanings for each party, become intractable and severely compromise the therapeutic relationship.
- This study provides a robust interpretative account of nurses' and drug users' struggle with moral relativism and their respective routines and rituals in attempting to manage pain in the acute care setting.
- Proactive pain management based upon informed interaction in situated contexts is advocated rather than dependence upon checklists or urine screens.
- Pain management education and training needs to specifically address the issue of managing pain in drug users in all areas e.g. pre-registration (nursing) curricula, undergraduate/post-graduate curricula, Junior House Officers FY1/FY2 training.
- Any educational input to healthcare staff on pain management in drug users needs to address the issue of moral relativism constructively and in a non-threatening way. Knowledge deficits e.g. Opioid Induced Hyperalgesia cannot be addressed by information alone.

- It may be useful to convene a multi-disciplinary working group (NHS Lothian/ University of Edinburgh) to discuss possible actions arising from the findings of this report specifically logistical/practical issues (a) accessing drug users' (methadone) prescriptions at the weekend and (b) more specific approaches to prescribing and dispensing medication.
- Further research involving longitudinal, observation-based inquiry could enhance the substantive theory and an action research approach may also better develop the clinical-practice gap.

<u>CONTENTS</u>	<u>PAGE</u>
INTRODUCTION	8
LITERATURE REVIEW	8
METHOD	9
FINDINGS	16
The Theory	16
Stigma and Sensitivities	19
Tolerance	23
Routines and Rituals	28
Aberrant Behaviours	29
LIMITATIONS	34
CONCLUSION	35
IMPLICATIONS FOR RESEARCH AND PRACTICE	35
DISSEMINATION	37
REFERENCES	46
APPENDIX I	46

INTRODUCTION

Drug misuse is a major global health and social problem (Monteiro 2001). Approximately 11% of all emergency admissions are likely to include drug users, mainly injecting drug users (Sinclair 2003). Injecting drug users primarily present as emergency admissions to hospitals with direct drug use-related (bloodborne viruses, abscesses, endocarditis etc) or lifestyle-related harm (e.g. trauma) (ISD 2008). Drug users are also likely to have complex co-morbidities (Rassool 2002, Shuckit 2006). However, 86% of these patients remain in hospital for less than one week (ISD 2008) are poorly managed and may take irregular discharge (Jage and Bey 2000a, Kurtz 2003, McCaffery and Pasero 2001).

LITERATURE REVIEW

Drug users¹ present unique challenges in acute care settings with pain management (BPS 2006) noted to be sub-optimal or non-existent (Pawl 2006, Jage 2004, Kurtz 2003). This may contribute to the irregular, discharge rate among this cohort of patients (Jones 2002, Jage 2004, Kurtz 2003, McCreddie 2002, Morrison 2000, Pawl 2006). Other factors such as limited staff knowledge and fears plus Opioid Induced Hyperalgesia² all complicate the presentation.

The terms ‘drug-seeking’ or ‘red-flag behaviours’ are commonly cited within the literature with regards to drug users who are viewed as either addicted, abusing medications or manipulative (McCaffery et al 2005, Morgan 2006). Nevertheless, the predictive value of ‘red flag’ behaviours has not been validated (British Pain Society 2006). Morgan (2006) and Passik et al (2000) suggest that hospitalised drug misusers simply use aberrant behaviour as a means to an end e.g. analgesia for under-medication.

¹ Drug user is the preferred term here, rather than drug misuser – both apply to people who use illegal drugs. However, the former is preferred as it more appropriately represents the broad spectrum of drug use (and users). Drug misuse refers to the Drug Misuse Act (1971) - United Kingdom legislation that has subsequently been amended several times.

² Opioid induced hyperalgesia: the development of a hyperalgesic syndrome following effective opioid administration (legally or illegally). Hyperalgesia is increased pain perception or sensitivity to a minimal stimulus. Increased pain perception was previously thought to be a phenomenon of pharmacological tolerance. Current evidence suggests there may be a variety of mechanisms which explain this paradoxical phenomenon (Angst and Clark 2006, Compton et al, Doverty et al 2001, Fallon 2008, Mao 2006).

However, nurses are also noted to strategise regarding pain management (Manias et al 2005) and may stigmatise patients as drug-seeking (McCaffery et al 2005) via inferred rather than actual behaviour (McCaffery and Pasero 2001) e.g. pseudo-addiction. There is therefore, arguably a relatively indistinguishable line between the stigmatising of aberrant behaviour (or red-flag behaviours) and pseudo-addiction (Weissman and Haddox 1989)³.

Drug users continue to be admitted to acute care settings and present challenges to clinicians potentially less experienced and knowledgeable in managing complex co-morbid addicted patients. Consequently, pain management of these patients may be compromised leading to unsatisfactory experiences for both patients and staff. This study explores the perceptions and strategies of drug users and nurses with regard to pain management in acute care settings.

METHOD

This study applied a Constructivist Grounded Theory approach (Chamaz 2006). Grounded Theory offers a flexible approach via theoretical sampling and is especially appropriate for areas of investigation where there is limited existing data (Morse 2001).

Sampling: recruitment and sites

Participants (drug users and staff) were recruited from three acute general hospital sites within the same health board area (hospitals 1 – 3). The research project was outlined at local briefing meetings highlighting the inclusion/exclusion criteria [Figure 1] with information sheets and contact details provided. Clinical areas contacted the research assistant (RA) directly or via clinical members of the research team. The RA obtained written consent from those patients who indicated willingness to be involved in the study.

³ Pseudoaddiction was a term applied to drug seeking behaviour by patients who were actually under-medicated (Weissman and Haddox 1989).

- English speaker
- Current or recovering drug user
- Polydrug use: heroin main drug of use
- Presenting problem or condition includes (self-report) acute pain
- Previous admissions to acute care settings in drug 'career'

Exclusion

- Intoxicated/overdose
- Any mental status impairment that would negate ability to give consent
- Psychological crisis
- Alcohol only abuse
- Severe pain

Figure 1: inclusion/exclusion criteria

Glaser and Strauss (1967: 56) suggest data sampling should minimize variation initially and then seek to maximise differences in order to 'saturate' categories. It was hypothesized that drug users' rituals and staff's organizational working practices should not vary considerably over a limited geographical (health board) area. Therefore, variation was initially minimized by restricting the participants (drug users in acute care setting) and the geographical area under investigation. Data driven theoretical sampling (Charmaz 2006) commenced from participant seven onwards.

Grounded theory is founded on symbolic interaction (Blumer 1969) where interactions, actions and processes are reviewed through meaning, thought (introspection) and language (Milliken and Schrieber 2001). At this juncture it became apparent that participants were not providing adequate introspection on the phenomenon to facilitate researcher-participant co-construction of data. Different perspectives on the phenomenon were required to extend the data, saturate categories and develop theory [table 1].

Table 1: participants and perspectives

Participants	Perspective
Drug users in acute care settings	Drug users' current experiences of pain management in acute care
Drug users in non-acute settings but in treatment	Drug users' previous experiences of pain management in acute care from a less acute perspective
Acute Care Staff	'Expert' Acute Care staff's/non-expert addiction perspective
Community Addictions Staff	'Expert' addiction view on issue
Pain CNSs	'Expert' pain and non-expert addiction perspective
Ex-drug users (recovering) in the community	'Expert' retrospective patient view
Infectious Diseases staff	Staff experienced in working with drug users in acute care settings

Theoretical sufficiency was declared in relation to theory development on the basis of decreasing data interrogation, the variety of data and data sources in conjunction with literature saturation. [table 2].

Table 2: constant comparison - timelines

Sampling	What	When (2008)	Level of Analysis
Purposive sampling	Drug users recruited and interviewed as in-patients at three hospital sites: Participants 1 – 6	April – May	Open coding
Theoretical Sampling	Include non-acute	May	Open coding

Issue of can drug users provide introspection?	drug users: Participants 7 & 8		
	Continue with drug user in-patients: 9 – 11	May – June	Open coding
Decision to contrast emerging data with Acute Care staff perspective	Focus Group with Acute Staff: FG 1 n = 8	June	Open – axial
Decision to obtain a ‘more detached’ perspective from CAS	Focus Group with Community Addictions Staff	June	Open – axial
Attempt to corroborate above with Acute Care staff	Focus Group with Acute staff and Pain CNSs FG 2 n = 2 (CNSs only)	June	Open – axial
Attempt to extend emerging theory with the potentially more insightful recovering drug users’ perspective	Focus Group with Recovering Drug Users FG 3 n=4	June	Open – axial – Selective
Attempt to ‘round’ theory with ID staff perspective	Focus Group with Infectious Diseases Staff/other FG 4 n=3	June	Open-axial – selective
Suspend sampling			
Further theory development	Further Analysis	July – November	Axial - selective

Research report to funders February 2009:
Pain management in drug users in the acute care setting

		December	Theory delimitation
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Data collection and analysis

Theoretical sampling incorporated the constant comparative approach to data collection and analysis. This iterative process compared emerging data against literature and included presentations at two pain conferences⁴ as part of theory development. Data comprised 11 interviews with drug users (table 3), 5 focus groups (table 4) and memos. All interviews and focus groups were recorded and transcribed verbatim and research team members undertook and shared memos. A minimum of four passes were undertaken on each transcript and Strauss and Corbin's (1990, 1998) coding paradigm of open, axial and selective coding was applied. The research team reviewed data individually and via group data sessions principally at the level of open coding. Open coding focused on gerunds (action words), in vivo codes, relevant constructs and discussion of same.

Table 3: drug user participants' interviews

Patient	Site	Gender	Age	Presenting Condition	Addiction	Pain Management	Other
1	1	Female	39	Abdo pain	Ex-IVDU, meth	Methadone	Flat
2	1	Male	32	Laparotomy	IVDU, Alcohol, DF118 (16)	PCA Ketamine DF118	SA
3	2	Male	26	FAR	Ex-IVDU Meth	Prev PCA Morphine, Sevredol	Hotel

⁴ British Acute Pain Symposium (September 2008), Scottish Society of Acute Pain Services (November 2008).

						DF118	
4	3	Male	32	Fracture	Ex IVDU Meth	Oxyconton, opiods	Flat
5	1	Male	58	Bowel Cancer	IVDU Diazepam	Prev - PCA morphine, paracetamol, local	Flat
6	2	Male	33	FAR	IVDU	Morphine PCA – MST Sevredol	Hostel
7	CAS	Male	29	-	-		Flat
8	CAS	Female	23	-	-		B&B
9	2	Female	36	Abdo pain/constipation	Ex IVDU Meth Diazepam	Voltarol, paracetamol Meth Diazepam	Flat
10	3	Female	41	Dental Abcess	Ex IVDU Meth	Co-codamol	Flat
11	2	Male	35	FAL	Ex IVDU Alcohol Meth	Tramadol, Diazepman Tramadol Prev PCA	B&B

IVDU = Intravenous Drug Use

FAR = Femoral Artery Repair

FAL = Femoral Artery Ligation

B&B = Bed and Breakfast Accommodation

Meth = Methadone

Table 4: Focus group participants

FG	Setting	n=	Gender	Age*	Experience	Other	Degree	IDU⁵ numbers
1	Acute 1	8	2 males	4 = <29	1 = < 2 3 = > 2 – 5 4 = >10	4 = RMN/RGN 1 = band 6 7 = band 5	4	Varied
2	Acute 2	2	-	3 = 30 – 39	2 = >10 Pain specialist	2 = band 6	2 plus 1 masters	Very Often
3	Community Addiction	6	3 males	1 = 30 – 39	5 = >5 -10 1 = > 10	4 RMN/RGN 1 = band 6	3 incl 2 Drs	Very Often
4	Recovering Drug users	3	3 Males	1 = <29	recovering IDU	NA	NK	-
5	Infectious Diseases	3	-	1 = 30 - 39	3 = >10	3 = band 6	Nil	Very Often
	-	22	-	-	-	-	-	

Ethical Issues

The explicit inclusion/exclusion criteria highlight the appropriate and ethical recruitment of participants. All data was stripped of any identifiers at an early stage and stored securely and the principles of research governance were observed (SEHD 2006). Ethical permissions were obtained from the Local Research Ethics Committee following minor amendments (08/S1102/9).

Theoretical sensitivity

Schrieber (2001) notes the importance of being sensitized to emerging data yet not imposing particular concepts. Theoretical sensitivity in this study was engendered by the

⁵ How often IDUs present in their respective clinical areas

following: (a) the diverse research team (b) a literature review and (c) participant-researcher co-construction of data. The research team included ‘expertise’ in clinical pain management, drug use/addiction and the sociolinguistics of pain - an academic-clinical collaboration with patient involvement via a recovering drug user (Beresford 2007).

Reflexivity and scholarship

Every qualitative study should be judged on its merits (Rolfe 2006) and reflexivity (Finlay and Gough 2003) consists of more than simply making findings and researcher-participant dyad open to scrutiny. An explicit data trail, conference presentations and the participation of patients and staff attest to study transparency. The reader may wish to judge the theory on the basis of Glaser’s (1978, 1992) key criteria for evaluating grounded theory: fit, work, relevance and modifiability.

FINDINGS

The theory

The struggle with moral relativism, routines and rituals: a grounded theory of pain management in drug users in the acute care setting

The theory contends that nurses and drug users struggle with moral relativism and their respective routines and rituals in managing pain in the acute care setting (see schema). Moral relativism purports that there are no ‘correct’ codes or behaviours. Morality can only be judged in social, historical and situated contexts with due regard for knowledge, experiences and beliefs. Moral relativism both represents the phenomenon and explains the basic social process.

Drug users lay claim to expectations of compassionate care and moralise via narration. Paradoxically nurses report that the caring ideal and the mutuality of caring are diminished compromising their therapeutic effectiveness. Both drug users and nurses struggle to authenticate pain and do so against the backdrop of sensitivities and stigma. Knowledge, fears and the extent to which nurses may be able to curtail aberrant behaviour mediates nurses’ ‘social’ tolerance of the drug user. Physiological tolerance is

Research report to funders February 2009:

Pain management in drug users in the acute care setting

obscured by limited understandings of OIH and pseudoaddiction. Consequently, both protagonists display aberrant behaviours. Those behaviours may have different meanings for each party, become intractable and severely compromise the therapeutic relationship.

[see schema at appendix I]

Expectations and perceptions of pain management in the acute care setting

In this study drug users and nurses reported contrasting expectations and perceptions of the therapeutic relationship. Drug users expressed a moral imperative with regards to care and treatment. Drug users also appeared to claim individual morality via the narration of ‘stories’ that personalised and normalised their life. Alternatively, compromised caring was evidenced by nurses who reported a restricted mutuality of caring, potential ethical erosion and perceptions of reduced therapeutic effectiveness.

Drug users in this study expected healthcare staff to ‘show compassion’ (P5) and hospitals to be there ‘to help’ (P3). Moreover, drug users did not expect staff to be judgemental or ‘look down’ on them, attesting that in which case ‘they (nurses) shouldn’t be in the job’ (P1). Drug users invariably categorized staff as either good or bad e.g. individual nurses (there’s always one), particular groups of nurses (night staff, acute pain team) or hospitals⁶. They verified their *expectations* via approbatory comments illustrating nursing as important, ‘noble’ work (P11) invariably contrasting this with the explication of a negative *experience*. Although drug users expected non-judgemental compassionate care irrespective of their lifestyle ‘choices’ or behaviours, they still sought to explain or authenticate such behaviours.

Moralising via narration: *book by the cover – it hurts them to be normal*

‘I think they’ve judged the cover before they’ve read the book’ (P1).

The drug user interviews revealed their apparent need to narrate. Thus drug users’ ‘explained’ how their lifestyle ‘choices’ were attributable to some other event (e.g. a custodial sentence) or individual (e.g. a doctor): drug use was an immoral side-effect of some other unfortunate event. This therefore, contrasts with an alternative supposition of

⁶ Nurses are also noted to utilize a typology of ‘bad’ patients (Stockwell 1972, Johnson and Webb 1995)

the drug user who chooses to use drugs and pro-actively leads an immoral lifestyle. This justificatory narration simultaneously marks them out as being ‘different’ to the ‘normal’ drug user. Drug users arguably attempt to align themselves with the morality of the nurse sidestepping the appearance of different moral standards thereby laying claim to be members of the moral mainstream.

For example, P1 revealed she was a prostitute but stated that she has never committed theft to fund her drug addiction. Her drug addiction was apparently ‘caused’ by inappropriate prescribing by doctors for a back injury as a result of a reportedly violent relationship. Moreover, she made the distinction between (drug) ‘users’ and ‘abusers’, placing herself firmly in the former category and so attested to certain ‘standards’ of morality⁷.

Drug users are known to favour narrative or ‘war stories’ in interactions and these may become fossilized as they are re-told (Mosach et al 2005, Singer et al 2001). However, (non-drug using) patients also use narrative and disclosure as a means of engaging with healthcare professionals (Appel 2005, Greenhalgh and Hurwitz 1998) even in brief interventions such as weighing (Pillet-Shore 2006). However, there may be other factors influencing moralizing via narration:

Extract 1: FG5(ID): R1

- 1 I think some people, it really hurts them to be ‘in normal company’ and be
- 2 thought of badly. Then you think after all these years and all the things that
- 3 people do to attain their drugs, still hurts them to not, to, you know they want
- 4 people to think well of them. But then you know that’s a good thing. When
- 5 someone’s like that you kind of, you’ve got hope for them. You think well you
- 6 know, there’s something that you want us to accept you and like you. So that’s
- 7 quite a hopeful thing really, isn’t it?

⁷ The nurses on the ward however, were unconvinced by the ‘moral work’ or her story as evidenced by memo notes about this patient’s attempts to ‘borrow’ money from other patients and their unhappiness with this situation.

R1 above makes three striking claims. First, she acknowledges the hospital setting as normal and therefore, by definition, the drug users' environment as abnormal. She then juxtaposes the drug users' presumably immoral pursuit of drugs with what she perceives to be an incongruous need for approbation (lines 2 – 4). Finally she appears to suggest that 'need' is 'hopeful' and in so doing arguably makes some moral judgment, i.e. denotes this need as worthy (line 4).

A number of factors may contribute to the drug users' 'need' to narrate. The transient 'straight place' of the acute care setting may disempower the drug user via the sudden (and unwelcome) awareness of their drug addiction, in an unfamiliar environment with the concomitant potential for stigma and discrimination. Drug users may not be the most reliable historians. Nonetheless, it is not whether these 'stories' are true or false but rather why drug users elect to tell them in the first place *and* the way in which they do so.

Coping with the abnormal and immoral: compromised caring

Nurses working in the acute care setting, specifically surgical, are generally used to patients being admitted, treated successfully and discharged. The 'success' of their therapeutic endeavours and patients' approbation (Lotzkar and Bottorff 2001) arguably enhance nurses' satisfaction and self-worth (Healy and MacKay 2000): a pronounced mutuality of caring⁸ (Benner and Wrubel 1989). However, drug users may be non-compliant, aggressive, indulge in illegal behaviour and self-discharge (Manos and Braun 2006, Mehta and Langfor 2006, McCreaddie and Davison 2002). They are likely to be re-admitted for similar problems and are unlikely to offer praise and gratuities⁹. The caring ideal (Watson 1999), mutuality of caring (Benner and Wrubel 1989) and therapeutic effectiveness is therefore, *explicitly* compromised:

Extract 2: FG2(Pain)

PM1 I think some of the nursing staff think well why am I bothering? I'm trying my best here and you're doing something like that - or you've got the guy who broke his ankle and walked on straight away. You know he was walking on it but he

⁸ Benner and Wrubel denote the mutual relationship between caring and being cared for.

⁹ It is not unusual for patients to leave gratuities for staff such as coffee, chocolates etc upon discharge.

would not listen. () And it all comes back to time and if you constantly get that you're not going to take it from them. ()

PM2 Rather than seeing yourself as a failure you could put the blame in the other direction (uhu) its, it's maybe easier to cope with.

Notably, PM1 articulates a notion of prognostic pessimism (Howard and Chung 2002) while PM2 observes that the failure is vicariously that of the drug user. Thus, the self-worth of the nurse is less likely to be threatened by this unsuccessful therapeutic encounter. Nurses reported that the ongoing aberrant behaviour of drug users may lead to reduced tolerance or 'ethical erosion'¹⁰. Indeed, several drug users recognized nurses' were likely to have had poor past experiences with drug users (e.g. they would have 'got sick of it over the years' P4). Consequently, this may exacerbate stigma and sensitivities.

Stigma and sensitivities

Stigma

Drug users potentially share several of Goffman's (1963) stigma criteria (e.g. drug user: P1, HIV/HCV: P6, dirty: P7). They may be perceived as being responsible for an incurable, progressive disease that is not well understood with symptoms that cannot be easily concealed. Consequently, drug users reported felt stigma - experiencing negative attitudes (condescending/piece of shit – Cal, RDU) - or enacted stigma e.g. being more discreet in dispensing methadone (P8).

Several drug users suggested they were treated differently in comparison with other non-drug using patients (cancer, older people). Corley and Goren (1998) suggest that nurse behaviour simply mirrors societal behaviour while difficult patients have a history of being stigmatized by nurses (McDonald 2003). Therapeutic interactions are therefore, compromised and other aspects such as role adequacy, support and legitimacy may

¹⁰ Ethical erosion is a popular but unsourced reference to the notion that the motivation to act ethically may diminish over a period of time due to a degree of professional cynicism. For example, Wear et al (2006) note how doctors may use humour in expressing ethical erosion.

similarly impede good practice (Skinner et al 2005). Drug users' responses to (felt or enacted) stigma varied according to their attendant sensitivities or anxieties.

Sensitivities

Sensitivity is irritability to a real or perceived stimulus, such as stigma. This study noted a clear distinction between sensitivity and anxiety with the latter being a generalized mood state that confers a certain degree of uneasiness but requires no particular stimulus. *Anxiety* as a generalized mood state may be a pre-existing condition for drug users as part of a co-morbid presentation e.g. depression (NICE 2007). This *pre-existing condition* may be exacerbated by an acute admission.

Sensitivity however, arises as a consequence of the *stimulus of the admission*. As the drug user begins to experience the 'straight place' in unfamiliar surroundings sensitivities may emerge. This 'straight place' may provide the backdrop for various stimuli to provoke potentially disproportionate responses. There were three key dimensions within this sub-category: (a) '*pick a stitch*' (b) '*feeling like a piece of shit*' and (c) *anxiety*. '*Pick a stitch*' required recognition of the drug user's complex, difficult and sometimes abusive histories that may unravel within such an unfamiliar setting and state (e.g. a straight place) (Jarvis and Copeland 1997, Tyler 2002). '*Feeling like a piece of shit*' begets two aspects: (a) the need to be aware of the somatic presentation of the drug user (e.g. withdrawing, in pain, anxious, sensitized) with the concomitant (b) potential for felt or enacted stigma.

P9 perhaps epitomises the stigma and sensitivities relationship. He reported a nurse dispensing his methadone with: "*right blue eyes here's your green¹¹ monster*" which P9 met with the strident rhetorical retort: "*I take it you're anti-drugs are you? Well dinnae treat me like a piece of shit*". Thus, P9's account provides a more explicit enactment of the struggle with moral relativism which may be exacerbated further via anxiety and OIH.

¹¹ Methadone liquid preparation is green in colour.

Anxiety and OIH

Anxiety may be present as (a) a pre-existing co-morbid presentation (b) due to the emergency admission or (c) as a consequence of withdrawals. Moreover, hyperalgesia may be present due to persistent opioid use (OIH) or it may be exacerbated by anxiety.

Community addiction staff cited awareness of the ‘anxiety cycle’. They suggested that drug users may not be able to distinguish between anxiety per se and anxiety withdrawals. Managing withdrawal is central to managing pain as withdrawals will further exacerbate hyperalgesia (Du pen, Shen and Ersak 2007, Jage and Bey 2000b). Unless all of those factors are taken into account and managed appropriately early in the admission then it may be virtually impossible to arrest the anxiety cycle

Extract 3 FG3 Rec IDUs

Cal They eventually gave me some DF’s eh.

Int Right good. So that was the only medication they gave you. Em... did that help at all?

Cal Naw well no’ really cos I worked ma self up cos. - (*Int- aye you were anxious*) It kinda took eh... a wee bit of the anxiety away but at that point I’d got it into ma head that I was going home going to get ma Meth¹² and get sorted so I just worked ma self into a state of distress eh.

Cal reported that he subsequently self-discharged - not an uncommon outcome for this particular patient group (Morrison et al 2000). According to Cal’s account there is an ongoing failure to address his anxiety, pain and withdrawal that escalate until they become intractable. To what extent staff communicated with Cal effectively and whether this may have addressed the underlying physiological processes at work is uncertain. Nevertheless, communication is an integral aspect of healthcare no matter the patient group and this is reviewed in the following section on tolerance.

¹² Methadone

Tolerance

In this study the concept of (social) tolerance - forbearance (by staff of drug users) and (physiological) tolerance (to drugs) played a significant part in how pain was managed. Societal ‘tolerance’ facilitates the existence of another perceptibly aberrant grouping¹³ and as McDonald (2003) suggests the acute care setting may simply mimic society at large. Alternatively, tolerance is a pain management term used to describe physiological adaptations to the repeated administration of a drug over a period of time, necessitating increased amounts of the drug to achieve the same effect (Rosenblatt and Mekhail 2005). Drug users or chronic opiate users who use significant amounts will therefore, need those amounts *and more* to prevent withdrawal and manage pain.

The degree of (*societal and ward*) tolerance enacted was *mediated* by a number of factors including (a) staff *knowledge* regarding addiction and drug users (Howard and Chung 2000) (b) staff *fears* based upon unfounded illogical assumptions (Alford et al 2006) and (c) the extent to which staff *were able to limit* what they perceived to be *aberrant behaviours*. Thus, community addiction staff (high knowledge, minimal fears) managed aberrant behaviours assertively whereas acute care staff (low knowledge, significant fears) reported being less able to curtail aberrant behaviours. Individual medical consultant preferences reportedly created mutable boundaries and made balancing routines and rituals difficult. Moreover, staff noted that they were nurses, not ‘the police’ (R1:FG5-ID) and hence their role had certain parameters. However, the need to talk was highlighted as an important aspect of managing this particular patient cohort:

Talking

Community addiction staff claimed that ‘talking’ was part of their specific skill set in terms of working with people ‘from the neck up’ (FG3CA). Conversely, acute staff perceived drug users as ‘needy’ and considered that an on-call psychologist would be most useful as a treatment adjunct. Certainly, psychological assessment is an important

¹³ Tolerance may previously have been used to refer to minority groupings in society. Postmodern approaches to issues such as diversity however, suggest that the notion of tolerance per se may actually promote discrimination against minority groups. The integration of such groups into society may be hampered by the interpretation of tolerance as an act of forbearance rather than assimilation.

aspect of chronic pain and addiction management (Pawl 2006). However, there is a distinction between psychological intervention and simple communication (or interaction). Nevertheless, nurses perceived that ‘additional’ aspects of a drug user’s presenting condition, such as addiction, were not only beyond their knowledge and capabilities but arguably also lay outwith their role. Thus, fears regarding addiction, specifically the (abnormal) amounts of drugs being consumed were apparent:

Extract 4 FG5(ID)

R1 They’ve currently got somebody on MST 400mgs 3 times a day, plus (xx) dihydrocodeine and she’s off to the safari park today. So you think, oh my god! I can’t possibly give that, and that’s hard for new staff coming in. D’you know? Sheer numbers and frightening to give it, if you’re not used to giving that. Plus medical staff as well cause they’re not used to it either.

Extract 4 outlines the fears of staff in dispensing abnormal or unusual amounts of morphine. Doctors prescribe and nursing staff dispense medication. However, accountability is a central feature of nurses’ training and practice (Hart 2004). Nevertheless, nurses in ID and pain management who were more experienced and knowledgeable, were also reluctant to dispense prescribed medication. From the drug users’ perspective however, getting the ‘appropriate’ medication prescribed in the first instance, was the main priority:

Extract 5 – P5

P5 Well I know that if I’m in serious pain, opiate is the one that does the business. (I-uhumm) I mean if they try and offer you some scabby product way down the lines it’s insulting. You know what do you drive - what kind of car do you drive?

Int Me I don’t drive unfortunately.

P5 Well if you had a Bentley for instance. A nice you top of the range Bentley (I-uhumm) and eh,... you lost it. A skoda wouldn’t make up for the loss would it? (I- no) So when your familiar and well acquainted with the crème de-la-crème, chalk masquerading as pain relief - it’s deeply insulting (I-uhumm) especially if you are suffering pain its insulting to your intelligence, to your dignity. I mean it’s also criminal. Re-enforncing the pain it’s your error you shouldn’t have been

a junkie and I might have given you something better or it might have worked better.

P5 equates his perceived under-medication to be ‘criminal’ or maleficent and as a corollary, beneficence is (e.g. ‘it’s your error’) also noted to be absent.¹⁴ However, a third complicating factor may also act as an encumbrance:

Authenticating pain - nurses

Extract 6: (infectious diseases)

Whether there’s the sort of em, another reason that he wants it and that, that’s not appropriate. It’s not appropriate to give it out for acute pain, if it’s not you know that. If he was prescribed something else because he was withdrawing it would be much easier for us.

The nurse in extract (/) suggests that the individual’s pain claim may be fraudulent. Moreover, she delineates between medication for pain (genuine or otherwise) and medication for withdrawal. In this study staff wished to authenticate pain – to be assured of the integrity of the pain claim.

Chronic opiate users are much less likely to have side-effects such as respiratory depression e.g. overdose or over sedation, than non-opiate users (Alford et al 2006, Joranson 1995, Pud et al 2006). Moreover, their tolerance levels are such that it is unlikely they will obtain ‘a high’ or their (normal) enjoyment of the ritual, e.g. being wasted (Alford et al 2006, Jage and Bey 2000a). Nurses’ fears of potentially jeopardising the care of the individual leaving self and others open to legal, ethical, professional and moral scrutiny were therefore, relatively unfounded.

¹⁴ This arguably resonates with drug users’ perceptions of older people or cancer patients not being treated in a similar way.

Authenticating pain – drug users and pain overclaim

Drug users also reported the need to authenticate their pain. In authenticating pain, drug users could be (a) ‘genuinely’ in pain – e.g. OIH, (b) undermedicated (or displaying pseudo-addictive behaviours), or (c) be drug-seeking to achieve over-sedation.

Heit (2001) considers the term ‘drug seeking’ (or pseudoaddiction) to be simply another term for under-medication and as such, a generic term principally applied to non-drug users. Moreover, McCafferty et al (2005) noted that less than a third of nurses considered under-medication an option in relation to the term drug-seeking when applied to patients *not known to be addicts*. Thus, under-medication and the need to authenticate pain is not a problem specific to drug users, but may be more pronounced in drug users (Breitbart et al 1997, Newshan 1998). However, pain is subjective and this may also complicate presentation and subsequent interpretation (Spacek 2006).

Extract 7: A

P4 *And then after that I was really – ken - I was crying and I was shouting an, ken. Just trying to wriggle about the bed banging my elbows and everything just to try and divert the pain fae the, fae the leg a bit. . It wisnae working and then as ah... say at night time the staff wurnae helpful at all.*

Extract 7: B

P3 *I suffer (yeah) oh aye I suffer. And I feel like I’m being a nuisance to the other patients you know when I’m lying in bed trying to sleep at night and I’m giving it Oh...ah....ee....oh...oh...and I’m not joking that’s how it’s been you know.*

However, despite crying, whimpering, ‘greeting’, screaming or banging elbows, drawing attention to self and potentially being a ‘nuisance’ to other patients, drug users in this cohort rarely reported these acts successful.

Manias, Bucknall and Botti (2005) reported that patients (in general) were less likely to obtain pain relief the more effusive and explicit their complaints of pain while

McCafferty, Ferrell and Pasero (2000) noted that grimaces rather than smiling were likely to bestow analgesia. However, the struggle with morality and the nurses' 'need' to authenticate pain may mean that drug users are *even less likely* than other patients to obtain analgesia for their explicit complaints of pain.

While drug users' also attempted dialogue in order to obtain further analgesia, this act was also fraught with the potential for misinterpretation:

Extract 8: P3

I So I mean have you tried talking to them about it or.

P3 Yeah but I feel as if I'm coming across as maybe a bit cheeky.

It is unsurprising that drug users' analgesic suggestions may be perceived as 'a bit cheeky' by nurses given nurses' expressed fears (addiction, pain, aggression) and poor knowledge base undertaken in a role and setting in which they are expected to be both guardian and expert. Drug users who reported being specific about their needs regarding drug, route, amounts and times may risk exposing nurses' knowledge deficits. Moreover, explicit and comprehensive drug knowledge has been touted as a 'red flag' behaviour (Morgan 2006) and this was corroborated by the ID focus group. Patently a drug user will have *some* knowledge about drugs and their effects, specifically knowing what works for them at what time and by which route.

Drug users themselves however, accepted that pain overclaim may be more than just under-medication or OIH e.g. 'there are tryers' and 'putting on an act' (Cal). However, the extent to which this 'act' is successful within the confines of the routine of the acute care setting is debatable.

Table 5: Perceptions of authenticating pain

Nurses	Drug users
Perception of ‘simple’ fraudulent overclaim (grounded in ‘normal’ subjectivity of pain and perception of <i>addiction per se</i> not pseudo-addiction)	Expect under-medication = pseudo-addiction (in such circumstances patients are usually undermedicated)
potential for oversedation (negligence - professional)	OIH – actual distress (comfortable) Over-sedation unlikely due to tolerance
Potential for fraud/illegality = legal high (moral)	Desire for legal high via inappropriate overclaim or ‘putting on an act’ (wasted)

Routines, rituals and rattling

Routines and rituals provided the fulcrum around which authenticating pain and preventing withdrawal took place. There was a notable clash between the routines of the wards and the rituals of the drug users and their respective ‘needs’ to adhere to those codes. Rattling – the onset of withdrawal – was a significant driver in both routines and rituals and created the greatest challenge:

Extract 9 - A

P(2) If they dae come round they would say you need to wait till the doctor comes round. And the doctors no’ round to the next flaming day and by that time your rattling. And you’re fucked.

Extract 9 - B

P8 It’s like I’m used to taking Methadone in the afternoon or whatever and they were giving me it at 8, naw 8 o’clock in the morning sorry they gave me it. I said ‘8 o’clock in the morning?! I can’t take Methadone at 8 o’clock in the morning because it will wear off’. If I’m used to taking it at a certain time then they’re just going to mess my normal routine up, know what I mean?

Failure to prescribe medication for withdrawal or pain is likely to make both more difficult to treat (Jage and Bey 2000a). However, prescribing medication outwith normal routines or 'rituals' may compromise the perceived effect of the drug for the patient.

Rituals are an important facet of drug use and are associated with the paraphernalia and environment of drug use (Derricott, Preston and Hunt 1999). Drug users will have a particular ritual such as the order and manner of setting up injecting equipment (Taylor et al 2004). The ritual may ostensibly act as a comfort blanket and afford some degree of order in an arguably otherwise chaotic lifestyle. Rituals are important whether they relate to heroin, methadone or benzodiazepines.

The drug users in this cohort had an appreciation of a busy hospitals' need to be organised in a specific way e.g. routines. However, the ritualistic practices of the drug users have evolved to maintain their minimum levels of need i.e. preventing withdrawal, and these practices were apparently unable to be accommodated by hospital routine. These rituals may also involve some behaviours perceived as aberrant e.g. using mobile phones, smoking near oxygen. However, it is argued that such instances are not necessarily part of a deliberate attempt to explicitly challenge ward routine. Further, aberrant (or ritualistic) behaviours are not only the preserve of the drug users.

Aberrant behaviours

There are three important points that preface this concluding section. First, aberrant behaviour may not be aberrant behaviour but 'normal' for the individual concerned. Second, it is important to distinguish between initial problematic behaviour and prima facie cases of aberrant behaviour. Initial problematic behaviour may arise out of the poor past experiences of either party. Moreover, 'aberrant behaviour' is a meaning that arises out of interactions and introspection¹⁵. Finally, aberrant behaviours are not the sole preserve of the drug user. The struggle with moral relativism ensures that healthcare staff may be equally culpable.

¹⁵ E.g. the nurse perceives the behaviour as pseudo-addictive, the drug user as undermedication.

Prelude: covering up

Drug users' aberrant behaviour may be a graduated, incremental approach to achieving a desired endpoint e.g. analgesia. The extent to which certain 'steps' in this process are enacted is dependent upon numerous factors highlighted previously including staffs' knowledge, fears, ward routine and the drug users' physical and emotional state. Prelude is proposed as the first 'red flag' in this process. A prelude is a preceding event, something that serves as an introduction for what is to follow. Notably, the following behaviours have not been reported elsewhere.

Drug users in this study reported what appeared to be a need to shut out the unfamiliar environment of the ward setting:

Extract 10: P3

Like you just lie in bed put the cover over your head and forget you're there (I- yeah). But some of them come in and keep on at you getting up, you getting up you know (I- yeah) like your ma getting you up for school (laughs).

Other drug users reported pulling the screens around their bed or putting a blanket over their heads. Nurses are probably intolerant of closed bed curtains as this prevents observation of the patient and may also play upon their fears of overdose and illegal drug use. Where a drug user adopts this behaviour it may not necessarily be indicative of an escalating problem, but it is arguably worthy of some kind of intervention. While closing bed curtains and hiding under blankets are relatively anodyne acts the drug user may also attempt to block out their surroundings for specific reasons in a more explicit and confrontational way. Thus, P1 reported hearing a patient's visitors use the term 'junkie' and 'hep c'¹⁶ repeatedly and responded by turning the volume on her bedside television up, causing a confrontation to ensue.

Upping the ante – cranking it up

'Covering up' may proceed to 'cranking it up'. In this instance a public audience (e.g. patients, visitors) is useful for airing grievances. Co-existing aberrant behaviours may

¹⁶ Hepatitis C – a bloodborne viruses highly prevalent in injecting drug users who share injecting paraphernalia.

involve ‘topping up’ or the use of illegal drugs. Aggression and brinkmanship, in terms of threatening irregular discharge may follow with irregular discharge the final act.

Audience and vulnerability

Infectious disease and community addictions staff noted the importance of an audience in terms of ‘upping the ante’. Their way of dealing with this particular difficulty was to remove the patient from the audience. This may be relatively easy in a community addictions setting and an infectious disease ward with single room accommodation. Most acute care settings however, have a traditional nightingale layout or four bedded bays (Pattison and Robertson 1996). The acute care drug user may also be bed-bound. Moving the patient to another area in a bid to address their grievances is therefore problematic.

Nurses were also fearful of aggression (Boles and Miotto 2001). Acute care nurses used a number of terms resonant with war e.g. frontline, fight, battle, to describe their interactions with drug users. Conversely, community addiction staff described drug users as ‘prey animals.’ They noted the cohorts’ vulnerability and suggested this may surface in exaggerated, attention-seeking behaviours that were almost child-like.

Topping up

Some drug users openly admitted acquiring and using illegal drugs (‘topping up’). Alternatively, they may threaten to do so if they perceived their pain and withdrawal needs were not being met. Of course drug users may elect to ritualistically ‘top up’ irrespective of how well their care and treatment is managed. However, it is reasonable to suggest that drug users are more likely to ‘top up’ when they perceive themselves to be under-medicated, in pain and, or withdrawal.

The dichotomy of subjective versus objective pain management of drug users

It is argued that the struggle with morality is manifest in nurses’ aberrant behaviours. The role of guardian and expert and the concomitant rules and routines of the acute care

setting provide a backdrop for a very subjective response. Limited knowledge, fears, issues of role adequacy and disempowerment all contribute to nurses' behaviours.

Pain scales and avoidance

Effective pain management is generally accepted as being safe and effective analgesia without unwanted side-effects (Etches, 1999). Pain scales are used to assess a patient's pain and analgesic requirement and are a pivotal feature of pain management in acute care settings. However, there are numerous difficulties with their application and interpretation (Jensen and Karoly 2001). Pain scales assess the patient's perception of pain and their response to analgesia over a period of time. Pain therefore, is subjective and needs to be assessed and treated regularly:

Extract 11: P4

P4 I buzzed her and said can I get another one of my Oxynorm. 'Again! Ah said 'aye I'm in pain.' 'What rating out of ten?' I said 'a 7,' 'well wait till it gets to about 8 or 9 and gies a shout.' I says 'well what's the point in that because by the time it gets to that I'm going to be in real agony and it's going to take longer for the pain killer to take the pain away you ken.'

Extract 12: Jed (recovering)

Int Did they ask you about a pain score? Did they say –like?

Jed Aye on a scale fae one- ten (aye) aye.

Int And what did you say?

Jed A hundred and ten (All laugh)

Int and they didnae believe you?!

A key tenet of pain management is regular medication and the appropriate titration of analgesia (Carroll et al 2004, Compton and McCaffery 2001). Both extracts illuminate some of the difficulties in using pain scales. Pain scales aside, nurses reported alternate ways of dealing with persistent pain claims:

Extract 13: FG 5 - ID

R1: But em, I think as the day goes on what'll happen is, people'll just kind of avoid him a bit, if they feel that they don't want to be giving that injection because they don't think

Research report to funders February 2009:

Pain management in drug users in the acute care setting

it's appropriate. So it's probably better that it's, the kardex is looked at and the prescription is looked at - then everyone's kind of in a zone where they feel quite happy to use it.

The patient referred to above is prescribed hourly sub-cutaneous morphine. The nurses reported being (a) unconvinced by the patient's pain claims and (b) unhappy with the prescription. This patient reportedly appeared at the nurses' station when claiming to be in pain and had also been repeatedly absent from the ward. When challenged on his absences he asserted that he might as well be in pain at the 'front door' than in the ward. Consequently, the nurses' reported that they avoided the patient and lobbied the doctors to amend the prescription¹⁷.

Individuals have varying pain thresholds and perceptions of pain and therefore have different ways of expressing and coping with pain irrespective of OIH and/or anxiety:

Extract 14: FG1 - Acute

There is always someone who is genuinely lying there in agony that will still go for a fag because they are a heavy smoker. I mean you help someone with colic going for a walk so why not give her something for the pain?

On the frontline

The acute care focus groups described the way in which nurses as non-prescribers often bore the brunt 'on the frontline' unsupported by others who could address the problem.

Extract 15: FG1 - Acute

I think it is more a medical issue. They need to get trained more than we do. Because if they are not doing their job then we can't do ours but we are at the front line where they are hiding behind the door.

Decision-making vis a vis appropriate prescribing was particularly difficult out of hours (e.g. verifying methadone prescriptions) and when new junior doctors were rotated. Thus, staff would bemoan the weekend admission of a drug user as it was likely to be

¹⁷ Issues re this prescription

'hell 'til Monday' (FG1). Alternatively, the acute pain team (APT) obtained accolades from grateful drug users delighted their pain was being authenticated. The APT were the 'goodies' to the ward staff 'baddies' while community addictions appeared to assume the role of the 'Sheriff!':

Extract 16: FG3- CAS

I think they recognise that they need us more than we need them at times. We have the Methadone, and the doctor has the pen in his hand then they are going to be nice to him because he is not going to sign the script unless they are. They will always pull back from the line, 99.9% of the time. So, as long as they know that those are the rules.

Thus, the power lies squarely with the nurses in managing these patients and their addictions in the community. Unfortunately, acute care nurses are arguably as disempowered as the drug users, low in self-esteem and with little or no support in a busy, demanding setting. They struggle with morality and attempt to establish their roles and routines over the rituals of the drug user even although they may, ironically, both have more commonalities than differences.

LIMITATIONS

There were several limitations with this study. First, this research was a fully funded study. However, contractual issues necessitated condensing an eighteen month study into a twelve month timeframe. Thus, the majority of data collection was undertaken over a shorter period than initially intended. The diversity of data collected during that time provided sufficient breadth and depth with which to saturate categories and develop theory. Nonetheless, a longitudinal approach to both data collection and analysis, specifically at the level of axial coding, may have produced different findings. Second, the staff recruited for the focus groups comprised a number of dual-qualified nurses who may have been (a) more motivated and open regarding the difficulties in this area and (b) more sensitive to and knowledgeable about the phenomenon. Finally, observation data may have added to the study specifically in corroborating findings such as 'covering up'.

CONCLUSION

This study provides a robust interpretative account of nurses' and drug users' struggle with moral relativism and their respective routines and rituals in attempting to manage pain in the acute care setting. Some of the processes involved in the aberrant behaviours of both parties (e.g. covering up, authenticating pain, avoidance) are outlined and the complex micro and macro conditions and the contexts that inform and influence subsequent behaviours made explicit. There are therefore, a number of implications for further research and practice.

IMPLICATIONS FOR RESEARCH AND PRACTICE

Despite pharmaceutical and technological advancements postoperative pain management remains problematic for all patients (Roth et al 2005). Education is often touted as the panacea to nurses' alleged deficiencies. However, nurses and their 'deficiencies' do not operate in a vacuum. They are human beings with values, attitudes and beliefs; some of which may have initially influenced their choice of career. The ward routine may provide a bulwark against a myriad of forces that threaten nurses' self-worth, identity and job satisfaction. Education may be part of the solution, but it may also be part of the problem. Nurses need to be emancipated; released from the shackles of algorithms, protocols and diktats that strangle their individuality and emphasize their lack of independent thinking.

The answer to improving the pain management of drug users does not lie in advocating urine screens (Passik and Kirsh (2005) or addictive behaviours checklists (Wu et al 2006). The answer lies in proactive pain management (Carroll et al 2004) based upon informed interaction in situated contexts – or to give it its old-fashioned nomenclature - communication. Communication based upon commonalities rather than differences is a more relevant, robust and durable approach than the arguably transient effects of education. Nurses may then begin to connect with drug users as people not problems. The struggle with moral relativism, its process and outcomes may therefore, become redundant.

There are clearly some knowledge deficits evidenced by healthcare staffs in this report e.g. Opioid Induced Hyperalgesia, tolerance, pain scales. Thus, specific input on these key aspects of pain management in drug users should be addressed as part of a general pain management input e.g. pre-registration (nursing) curricula, undergraduate/post-graduate curricula, Junior House Officers FY1/FY2 training.

Moral relativism permeates this issue and therefore, may negate any inchoate educational input. Thus, we contend that any educational input to healthcare staff on pain management in drug users needs to address the issue of moral relativism constructively and in a non-threatening way. It may be pertinent to involve recovering drug users in such input alongside skilled facilitators.

It may also be useful to convene a multi-disciplinary working group (NHS Lothian/ University of Edinburgh) to discuss possible actions arising from the findings of this report specifically logistical/practical issues (a) accessing drug users' (methadone) prescriptions at the weekend and (b) more specific approaches to prescribing and dispensing medication.

Further research involving longitudinal, observation-based inquiry could enhance the substantive theory presented here. A research approach that better develops the clinical-practice gap e.g. action research may also be appropriate. Moreover, language is clearly central to management of this particular issue in acute care settings for both drug users and nursing staff e.g. interaction in situated contexts. A discursive study (e.g. Discursive Psychology, Conversation Analysis) may therefore, be useful in reviewing what language is used in what sequence and to what effect.

DISSEMINATION

The emerging findings of this report have already been presented at the British Acute Pain Symposium (September 2008) and the Scottish Society of Acute Pain Services (November 2008).

An article has been prepared for submission to the International Journal of Nursing Studies (impact factor 2). There are plans for a more clinically-focussed article to be produced for submission to a more accessible journal as well as a narrative piece.

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Research report to funders February 2009:
Pain management in drug users in the acute care setting

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