Doing the Right Thing: Using Hermeneutic Phenomenology to Understand Management of Wound Pain

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Despite the availability of assessment tools, analgesic medications, and technologically advanced dressings, achieving adequate pain control in wound care continues to present challenges for healthcare practitioners, patients, and their families. Pain in general has been the subject of much clinical and scientific investigation, but most has focused on the biological aspects of pain management. The psychological aspects of pain management and factors stemming from the relationship between caregivers and care recipients have received less attention. Relational issues are particularly relevant when dealing with medical procedures that involve a caregiver actively touching a care recipient. This paper explores pain management in chronic wound care, particularly at dressing change, with an emphasis on the relational aspects of care. Work from a recently completed hermeneutic phenomenological study of 18 registered nurses performing wound care in long-term, acute, and community care suggests strengthening the therapeutic relationship between patient and nurse may have a positive impact on healthcare providers' pain management practices and patient quality of life. Although nursing was the focus of the study, the observations provided are relevant for any clinician providing hands-on, compassionate wound care.

KEYWORDS: chronic wound, quality of life, pain management, therapeutic relationship

Ostomy Wound Management 2008;54(4):52–60

Wound care is a nursing process with multiple components. It involves not only the physical task of changing or applying a dressing, but also the need to assess the physiological and psychological parameters of the patient’s condition. Much has been written about the expectations inherent in these activities. Observation of nurses changing dressings indicates that a holistic perspective is not always considered. A sizable gap exists in the research literature regarding nursing practices relevant to dressing changes and appears to be little understood or explored. Because nurses’ actions have

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a profound effect on healing and patient quality of life, it is important to understand the nurses’ perspective on changing wound dressings in order to identify strategies to enhance healing and decrease pain at dressing change.

Multiple research approaches facilitate knowledge generation. One—phenomenology—explores individuals’ experienced relationships with the world in order to understand the meaning of phenomena as completely as possible. Hermeneutic phenomenology offers a way to understand what a particular event—e.g., changing a dressing—means in practice. This approach reflects the context, life processes, tacit understandings, and social meanings that are powerful components of wound care provision.

Hermeneutic phenomenology examines in-depth interviews between researcher and participant to facilitate interpretation of the participant’s experience that can be distilled and described in a way that engages the reader to explore the depth of the experience and come away with a deeper understanding of what the experience is like. This approach does not offer the hypotheses or generalizable findings of quantitative research. Rather, it opens a window on experience that reveals greater awareness and opportunity for change and understanding. Qualitative research is based on a tradition of observation and interpretation (as is quantitative research) but in this case, the observer and the participant engage in a relationship that delves into the meaning of the experience, not just its observable facts.

For these reasons, this article is intentionally structured to elucidate the issue of pain in wound care. The purpose of this study was to provide an interpretation of the nurses’ experience of changing a dressing that would resonate with the clinician audience and offer perspectives that could enhance practice.

**The Chronic Wound Situation**

Older adults are particularly susceptible to the development and persistence of chronic wounds and their negative sequelae. For example, an 85-year-old woman with long-standing diabetes, arthritis, and congestive heart failure, admitted to hospital because of pneumonia, would be a likely candidate for a pressure ulcer in the sacral area. Her age, impaired circulatory system (including microcirculation impacted by long-standing diabetes), decreased nutritional status, and difficulty mobilizing combine with her parchment-paper thin skin, her bony prominences barely covered by undernourished tissue, and her general frailty and powerlessness to insidiously affect skin resilience and rob tissue of blood flow. Hence, a pressure ulcer is probable.

If the ulcer is painful due to its location over a bony prominence and/or infection, this elderly woman will hurt when she moves in bed or tries to get up to sit in a chair. She then will find comfort in lying still, which maintains pressure on the sacral area but increases the potential for pressure ulcer development in other areas of her body (e.g., heels, elbows, shoulder blades, and back of the head). If she cannot get up easily, she may have episodes of incontinence. She then may be put in an adult diaper, which will create a moist, acidic environment conducive to skin breakdown. With decreased mobility, she also may lose her appetite (which may have been poor already). The ulcer pain may make her feel queasy or anorexic. Nutritional deficits (albumin, pre-albumin, and serum zinc lab values) will diminish her body’s ability to heal. Her ongoing discomfort may disturb her sleep, leading to fatigue. Her feelings of dependence and helplessness may increase. She will be at risk of becoming depressed. Together, these challenges create a barrier to wound healing and can exacerbate pain during dressing changes.

**KEY POINTS**

- The overview of current research provided suggests that many factors conspire against the ability of healthcare professionals to provide effective pain management.
- The voices of nurses, as reported by the researchers, indicate they want to protect the patient from physical and psychic wound pain.
- Barriers to optimal wound management are explored and suggestions to improve care are provided.
The relationship between patient and caregiver at dressing change includes verbal and non-verbal communication. A patient who feels dependent and helpless will be more likely to passively accept pain as unavoidable and not bother to tell the nurse that a dressing change is causing pain. Similarly, the nurse may avoid exploring the issue of pain at dressing change because of time restraints. If the patient does not volunteer the information, the busy nurse may perceive the pain isn’t bad enough to require assessment or action. In addition, because dressing changes are repetitive in nature, a patient who experiences a painful dressing change once will be expecting the same experience at subsequent dressing changes. Often, the act of simply touching the dressing can elicit a flinch or groan from a patient who has had previous painful dressing changes.

**Pain Management and Wound Care**

This scenario, though common, is unacceptable by today’s standards. It has been established that poorly controlled pain can retard the healing process in an existing ulcer or contribute to the development of skin breakdown in an at-risk individual. Consideration of pain management is essential in the healing cycle: if one looks at the effect of stress on healing, it is clear the experience of pain creates the stress cascade, coined by Hans Selye in the 1950s to describe the “fight or flight” mechanism of the body. Confronted by a stimulus (the expectation of pain), an individual experiences increased shallow respiration, tensed muscles, decreased blood flow to extremities, and hypersensitivity to environmental sensation, including increased sensation of pain. Decreased blood flow affects the body’s ability to transport oxygen to the affected area, thus slowing the healing process.

Pain management can be described as “the elimination or control of pain, with a goal of restoring comfort, quality of life, and the capacity to function as well as possible, given individual circumstances and the source of the pain.” Despite the fact that pain processes have been articulated for more than two decades and effective medications are available, it is evident that healthcare providers (primarily physicians and nurses) still do not seem familiar with best-practice applications for pain management in general and wound care in particular. Available resources often are used inconsistently, inappropriately, or ignored completely.

Relevant reviews indicate patients (particularly the elderly) report their pain is frequently undertreated. In a study examining the relationship between nurses’ empathetic responses and their pain management practices with patients after coronary artery bypass graft (CABG) surgery, convenience samples of consenting nurses (N = 94) and patients (N = 225) from four cardiovascular surgical units in three large metropolitan teaching hospitals were surveyed. Patients identified pain as moderate to severe, yet nurses provided only 47% of patients prescribed pain medication. Patients did not perceive the nurses as resources or as attending to their pain. A 10-year (1992 to 2001) review of quality improvement data from 20 studies on inpatient pain management in eight US hospitals identified that while pain assessment indicators and documentation had improved, the intensity of pain and its negative effect on quality of life had increased. Nurses frequently estimate patients’ pain inaccurately and overestimate the degree of pain relief. It is not unusual for patients to report persistent moderate to severe pain following discharge from hospital, with minimal effort on the part of the healthcare providers to address the issue.

**Value-laden Aspects of Chronic Wounds and Pain**

The values of patients and caregivers are influential in determining treatment processes and outcomes. Despite their best intentions, caregivers may pre-judge or make assumptions about a patient’s behavior based on internalized attitudes and values. Elderly or confused patients may be expected to have less sensation of pain than younger more cognitively intact individuals and may be thought of as over-reacting to the removal of dressings.

As asked to describe the impact of pressure ulcers on their lives, eight respondents in a qualitative study (seven men, one woman, ages 27 to 52 years) with either current or healed pressure ulcers described pain, grieving, and the psychosocial impact of their ulcers. This would seem consistent with the experience of elderly patients, who form the largest cohort of individuals with pressure ulcers. Pressure ulcers are
characteristically chronic conditions, sometimes persisting for many years. The elderly patient, as well as the ulcer, tends to be marginalized, whether at home, in hospital, or in the long-term care setting and treatment often is relegated to the “same old, same old”—“old” being equated with no longer a challenge, no longer of interest or value. A descriptive, comparative study of 32 individuals across the continuum of care with ulcers from Stage II to Stage IV identified that 87% of participants had pain in relation to their pressure ulcer, yet only 6% reported receiving any form of analgesia to deal with the pain.

**Ongoing challenges.** Optimal interaction, in which nurse and patient express and address pain management issues effectively, is fraught with ongoing challenges. Fear of analgesia (especially opioids and narcotics) is problematic for both nurses and patients. Misinformation and lack of information create a climate where appropriate medication may be refused by the patient or not offered by the nurse, with no opportunity to productively explore the issues. It would appear that some sort of middle ground is needed where the relationship between nurse and patient has “genuine engagement between the professional’s desire to do what is right and the client’s desire to fulfill his/her own wishes.”

Systemic issues also can erode the relationship between care providers and recipients, with dire consequences for pain control. The current climate of healthcare shortages can cause patients and nurses to feel they are caught in a de-personalized system, as beds become more important than the individuals who are in them and budgets appear more important than quality of care. Under these pressures, both patient and healthcare provider may withdraw from establishing a therapeutic relationship. When this occurs, the wound is isolated from the context of the whole person and the act of changing the dressing becomes a task to be completed as expediently as possible.

**Changing Practices: Raising Awareness of the Wound Pain Phenomenon**

Given the importance of pain control for wound healing, it is critical that nurses and patients begin to recognize and act on the need to decrease pain as part of wound treatment. Research literature addressing the nature of the pain management experience for either nurses or patients is scant and what little there is has been focused on patient rather than nurse perceptions. The impetus for the first author’s doctoral work primarily was to understand the dressing change experience to gain insight into what was viewed as the task-driven (and non-therapeutic) clinician aspect of dealing with chronic wounds.

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April 2008 Vol. 54 Issue 4 55
Study design. Using a hermeneutic phenomenology framework for the research enabled development of an interpretive relationship with the experience described by the 18 nurses who participated in the study. Potential participants were identified by the researcher’s healthcare colleagues and subsequently provided an invitation to take part in the study. These registered nurses, from across the continuum of care (acute, long-term, and community), provided wound care as part of their regular duties. They were not wound care consultants or specialists in pain management or palliative care. Their nursing experience ranged from slightly more than 1 year to 30 years; their ages ranged from mid-20s to late 50s. Interviews were conducted individually and away from the workplace and recorded and transcribed. The transcripts provided rich data for interpretation, which included art and literature to further illustrate the significance of changing a dressing had for these nurses.

While hermeneutic phenomenology does not purport to provide conclusions (although it is seductive to attempt to do so), the voices of the nurses in this study spoke with a powerful unity that imparted a message that should resonate with all wound care clinicians.

Study results: hearts, hands, and minds. While the literature regarding pain management points to the undertreatment and underreporting of pain, the nurses in this study spoke of the need to protect the patient from the discomfort associated with dressing changes. The nurses collectively approached wound pain, odor, and appearance as requiring the same relational context — in other words, they believed their role was to protect the patient from the physical and psychic pain associated with the wound. For example, one nurse said:

*I do my best to make sure my face doesn’t give away what I’m thinking about how awful the wound looks and smells. I don’t want him [the patient] to feel somehow I’m repulsed by this. It would make him feel so terrible, I know.*

Another nurse said:

*It’s important to make the environment as good as you can, to give something for pain before you even come into the room to do the dressing. That needs to be done before, so they’re not sweating in agony as you take off the dressing.*

While nurses understand how pain management should be incorporated into caring for the patient, they were clear that time, or lack of it, was an important factor in creating the right environment for optimal dressing changes. Although lack of time was a theme for the nurses in any setting, they recognized that patients needed extra time, which they endeavored to take despite the potentially negative impact on the rest of their work.

*You just do what you have to do. I know many times the nurses who work here don’t end ’on time’. You know you have to do the right thing or it’s hard to imagine that patient when you go home at the end of your shift. You don’t want to think that you skimmed on something. Comfort is a big thing to me. I need to make them [the patients] comfortable.*

The nurses’ responses in this study were not congruent with what appears in the research literature. The authors contend that one reason for this is that nurses were asked to talk about their experience with dressing changes unfettered by time or environmental constraints. The interviews, conducted in a neutral setting away from the workplace, lasted anywhere from 1 to 1½ hours. The interview was unstructured, to the extent that probing questions followed the flow of thought rather than directing it.

Nurses in this study were deeply concerned about the impact of the wound on the life of their patients. At the same time, they recognized the time restrictions that constrained their ability to attend to patients as completely as they would have liked. In addition, nurses described the lack of knowledge regarding appropriate treatments (eg, dressings, analgesia) that would have further decreased patient discomfort and pain at dressing change. As one nurse pointed out,

*I know some things [but] I get frustrated because I don’t seem to have the knowledge I need at my fingertips. When I’m in with the patient, I think, ’Gee, I should be doing this better’…but I just don’t know what to do.*

Although many facilities/institutions have specialists in wound care/pain management available, the nurse at the bedside needs to be able to address the less obvious (but still significant) issues affecting the patient’s wound experience. From the first author’s
research, it is evident that nurses want to do what they can to alleviate suffering and improve the quality of life for their patients.

One of the important things is to remember [each patient] as a person and why you're doing the dressing and how they feel... Anybody can be taught physically how to do a dressing. But I think you have to realize this person may inside be dealing with some issue while you're changing this dressing.

Summary of findings. As a research methodology, hermeneutic phenomenology opens a perspective that elicits not only information, but also context and motivation to effect change. Despite differences in age, experience, and setting, the nurses in this study spoke with one voice of the urge to protect the patient from the devastating reality of the wound (the appearance, the odor, the pain). They all identified time and lack of knowledge as key barriers to being able to “do the right thing.”

Removing Barriers to Addressing Pain

Learning to do the right thing. Formal education provides a way for students, nurses, and physicians to learn about current, evidence-based wound treatment protocols and pain management. A large survey* (N = 3,918) on pain in wound care conducted in Europe and North America found that while nurses acknowledge pain management is an important factor in wound care (particularly at dressing change), approximately 50% did not know which products decrease wound pain/trauma. This has implications for consistent use of pain management plans — it follows that if nurses are not aware of appropriate treatment options, they are less likely to articulate a plan of care and instead rely on whatever is close at hand.

Nursing interventions. Creating an environment that supports nurses in their full engagement with patient care is a challenge. Ideally, evidence-based, best-practice guidelines provide the means for nurses and other members of the interdisciplinary team to provide this kind of exemplary care. However, treatment decisions for patients with chronic wounds are often left to the “experts,” which tempers the need for
relationship building between the bedside nurse and the patient in the assessment and management of pain in wound treatment. While expertise is valuable, it cannot replace the bedside nurse’s rapport with patients. The wound/pain care specialist can do much to foster a collegial, learning environment that supports bedside nurses in developing confidence in their abilities in wound care management. For example, inclusion of wound pain- and trauma-related criteria for product selection would further enhance nurses’ abilities to choose dressings for optimal patient comfort by ensuring access across all practice sectors.

Provision of peer resources or “champions” allows the wound/pain expert to develop local expertise. Staff nurses providing this kind of leadership at the unit level must have access to educational programs and regular refresher events. When possible, at least one peer resource nurse (PRN) should be available on each shift. Although compensation for the additional work (aside from release time for educational sessions/meetings) is unlikely, the opportunity to develop a specialized skill set and to serve as a consultant (with back-up from the wound/pain experts) offers a level of professional satisfaction that nurses may find rewarding.

Such programs require the support and participation of not only Advanced Practice Nurses (Enterostomal Therapists, Clinical Nurse Specialists and/or Nurse Practitioners) who are the wound/pain experts, but also the support of management because providing release time requires human resource budget approvals. Educational support for the PRNs includes print and online resource material for staff at the unit level.

Recognizing the variety of work cultures among the different generations of nursing staff, particularly new graduates, management and supervisory staff need to provide updates that address variations in adult learning styles, including use of interactive small groups, email postings, videoconferencing, and web-based links to learning/refresher sessions. These options can help raise the profile and awareness of pain and wound management, as well as reinforce options for PRN involvement.

Patient/family interventions. Interventions that empower patient and family are also important. Patients with chronic wounds usually have other significant medical problems that may be the major focus of treatment decisions; however, the chronic wound may require time-consuming and potentially painful dressing changes. Patients (particularly the elderly) may be unlikely to question treatment decisions or make requests for pain medication because they do not want to “bother” the nurse, believing if they are “good” patients (ie, not demanding), they will get more prompt attention when they do make requests. Also, many patients are so focused on the cure or treatment they are not interested in talking about their pain; or, they have grown up in a culture passively acquiescent to whatever the healthcare team provides. Subsequently, they support a stoic view of pain — ie, grin and bear it. Patients encouraged to report pain may at least provide a benchmark to evaluate progress.

Posters and pamphlets can help create an environment that conveys the message to patients and families that the facility’s goal is to provide comfort, particularly to help control and manage pain. The availability of information through web-based, video, or audio programs, accessible at the patient bedside or in the visitors’ lounge, support the message that the patient/family are important members of the healthcare team and, as such, should be able to avail themselves of material on prevention and management of chronic wounds, the meaning of pain, and strategies/resources to alleviate pain. Plus, videos that provide relaxation, stress reduction, and humor are useful adjuncts to a patient-centered library.

Alternative therapies for pain management are also valuable resources, particularly with patients dealing with chronic pain. Acupuncture, the use of transcutaneous electrical nerve stimulation (TENS), therapeutic touch, and meditation are but a few of the options patients and their families may wish to pursue. If such resources are not available within the facility, information can be provided to direct interested individuals to appropriate services.

System impact. Pain and wound management are intertwined. How they are addressed within an institution reflects the larger concerns of bed management and resource allocation. Patients whose chronic wound pain is poorly controlled have decreased
healing potential. With poor pain control, patients are less likely to utilize the restorative powers of sleep, eat well, or mobilize, and they may require increased attention regarding breakthrough analgesic medication, dressing changes, and nursing time. All of these factors have an impact on the institution that must deal with the constraints of bed availability and human and material resources. With a view to supporting safe, patient-focused care, priority must be given to facilitating the institutional culture in which pain management is an integral part of wound care management.

Conclusion

The treatment of pain in chronic wounds is a key issue for patients, their families, and healthcare providers. Both the literature and observations within the clinical environment support the need for early and consistent assessment and treatment of pain. However, the reality of transforming the culture of understanding pain and applying evidence-based/best-practice guidelines to assessment, treatment, and evaluation of pain require significant commitment. If patients, families, and healthcare providers explore the meaning of pain, it is essential that appropriate treatment options to ensure pain is managed, decreased, or obliterated be available. When one thinks of the impact of pain on all aspects of life, it is clear that clinicians need to “do the right thing” and be both proactive and active in relieving the suffering of those for whom they care.

The nurses who participated in the research study described in this paper and the nurses with whom the author has spoken about the results of the study have expressed their commitment to the best care possible for their patients. Clinicians willing to engage “hearts, hands, and minds” in this endeavor must be provided the environment and the tools that foster the types of clinician-patient relationships that allow them to provide the kind of care to which they aspire. - OWM

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