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Patients' attitudes to analgesics and expectations of emergency care

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Abstract

Alleviating pain and suffering has long been a goal of health professionals. Pain has been shown to be one of the leading reasons that patients present to emergency departments (ED) throughout the world and the use of analgesics in ED's has been extensively explored. What has been less extensively researched is why some patients in pain choose not to use analgesics and what it is that they expect from emergency health care. The present work is an exploratory study looking at the attitudes of patients in pain, presenting to an urban ED and declining analgesics. It asks why patients decline analgesics and what they expect from emergency care. Seven participants were recruited over a two month period and volunteered to participate in semi-structured interviews while waiting to see a health professional. Four women and three men participated. Thematic analysis led to several themes being reported. People did not like taking analgesics because their injury was "not that painful"; they used "pain as a reference point"; and they had an "aversion to taking medications". Reasons for accessing emergency services included a "need to know what's wrong" and a belief that "diagnostic tests" were required. A surprising theme to emerge was the use of dental pain as a reference point for pain tolerance and pain behaviours. It was concluded that health professionals should accept that some patients in pain do not desire analgesics. Patients have non-pharmacological means of coping with pain. They access emergency care for diagnosis, active treatment, and have an underlying need to understand the cause of their pain. It is suggested that future study might include interviews with health professionals to compare and contrast their subjective perceptions with objective observations and to investigate the use of dental pain as a reference point.

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List of Abbreviations

| | |
|--------|---|
| ACC | Accident Compensation Corporation |
| CAM | Complementary and Alternative Medicines |
| C&CDHB | Capital & Coast District Health Board |
| DHB | District Health Board |
| ED | Emergency Department |
| GCS | Glasgow Coma Scale |
| GP | General Practitioner |
| HE&R | Maori Health Education & Recreation |
| LOC | Level of consciousness |
| MOH | Ministry of Health |
| MPQ | McGill Pain Questionnaire |
| NP | Nurse Practitioner |
| NZ | New Zealand |
| OTC | Over-the-counter |
| POP | Plaster of Paris (cast) |
| RAG-M | Research Advisory Group - Maori |
| RN | Registered Nurse |

Chapter One

Alleviating pain and suffering is a traditional goal of medical care (Beel, Mitchiner, Frederiksen & McCormick, 2000). Even the ancient Greeks and Indians used medications to "... alleviate pain ... calm the mind ... induce restful sleep" (Dormandy, 2006, p. 9). This introductory chapter will explain my background and interests in the area of pain and pain relief. To understand the project, the context of study will be explored, and this will include a review of the New Zealand (NZ) health system, definitions of pain, analgesics, over-the-counter medications and of help seeking behaviour.

Researcher's background

I have worked as a Registered Nurse (RN) for over twenty years and this research project was developed from working part-time as a triage nurse in a busy Emergency Department (ED) at Capital & Coast District Health Board (C&CDHB). With an undergraduate degree in psychology, when I was required to complete postgraduate study for my role as a part-time nurse lecturer, at Whitireia Community Polytechnic, it seemed logical to build on this and to merge my interest in psychology with my knowledge of nursing. I noticed that people were presenting to the ED without having taken any analgesics and when offered analgesics by nursing staff would refuse them. People were prepared to wait for long hours, while in pain, to see a doctor. There was never enough time to determine why they did not want analgesics or what they expected from emergency services, given that a major role of the RN in the department is to administer prescribed analgesics. This project has allowed me the time to question patients about their beliefs about pain, analgesics and expectations of emergency care.

Significance of study

Anecdotally, many people present to ED's without having taken any analgesics and when offered analgesics by health professions, they decline them. Nicol and Ashton-Cleary (2003) found that people had many reasons for not taking analgesics which included a belief that pain should be tolerated and a dislike to taking pills or tablets. Other reasons cited by the authors were referred to under the heading of "inappropriate perceptions of how pain killers may interfere with

their care” and included reasons such as “didn’t want to mask the pain” (Nicol & Ashton-Cleary, 2003, p. 228). What was interesting was that although their study somewhat answered the question ‘Why do people not take analgesics?’ it raised another issue of what are the expectations of patients in pain, who do not want to take pain relief? By increasing health professionals awareness of what it is that patients expect from emergency services one can provide education to both patients and staff as how to best meet the needs of the patient.

McLean, Maio and Domeier (2002) write that pain is one of the primary reasons people seek medical care. Fins (1997) writes that by understanding the attitudes that people have to pain and to analgesics, health professionals can develop educational programmes about pain management and reduce the ‘burden of pain’ on health services. The burden of pain refers to the large amount of resources used within health care services in the diagnosis, management and treatment of pain.

Context of study

To make sense of where this research project took place, that is, the context of the study, it is important to have some understanding of the health care system in NZ. For further clarification the processes within the Wellington ED, such as triage will be described. It is important to realise that care received through public hospitals is generally free whereas seeking health from primary care providers involves a cost to the patient.

New Zealand health system

At present in NZ government subsidies exist in healthcare and this is funded through taxes. Public hospitals are presently managed by twenty-one District Health Boards (DHB’s). The Ministry of Health (MOH) is responsible for the management and funding of the DHB’s and these DHB’s are responsible for the organisation of healthcare delivery and in meeting standards of care as set out by the MOH (MOH, 2008a).

Public hospitals treat all citizens or permanent residents free of charge and this includes specialist care. The costs of care for people presenting with injuries or trauma that have occurred as a result of an ‘accident’ are covered by the Accident Compensation Commission (ACC). Under ACC non-residents are also

entitled to public health care services if their presenting complaint is a result of an accident. Therefore, care delivered through all of NZ's public emergency departments is free of charge for *all* people presenting with an injury as a result of an accident.

Visits to primary health providers, such as General Practitioners (GP's), or Nurse Practitioners (NP's), are subsidised by the government however, patients are still required to pay the shortfall between subsidy and actual cost. This can range from ten dollars to fifty-eight dollars depending on which health care provider one sees (C&CDHB, 2007). This upfront fee for visiting a doctor can be reduced if the patient/family is earning less than a certain amount and meets criteria for qualifying for a Community Services Card. The structure of the New Zealand health and disability sector has been included as an appendix (see Appendix 1).

Department of Emergency Medicine

The Wellington ED treats approximately 45,000 patients per year, thirty percent of who are admitted as inpatients for further treatment and investigation (C&CDHB, 2008). Issues are constantly raised through the media as to overcrowding in ED's and on long waiting times to receive medical treatment/advice (Gower, 2008).

Research has been carried out into presentations at ED's in NZ as to whether or not presentations are 'appropriate' as determined by health professionals and whether by defining 'inappropriate' presentations, measures can be put in place to steer patients into more appropriate health care (Richardson, Ardagh, & Hider, 2006). However, little consensus can be reached among health care professionals as to what constitutes an appropriate presentation and little research has been done to investigate patients perceptions of appropriateness (Richardson et al., 2006). Patients are obviously presenting to these services with a perceived need for emergency care.

Triage

Within Wellington ED, triage is the process of immediate assessment by the first nurse to see the patient that presents to the department, with a perceived need for care. *All patients* (except those that are undergoing active cardio-pulmonary

resuscitation) that present to the ED are initially triaged by a triage nurse. This process may vary in other hospitals with medical staff rather than nurses actively triaging patients. Triage is a decision-making process based on the professional knowledge and skill of the health professional, and calls upon sound clinical judgment, thought and intuition (Mitchell, 1999). It is a core process in all emergency services.

There are several different triage scales used throughout the world' however they are all based on the need for the triager to make an assessment to determine the speed with which a patient needs to receive medical care. The Wellington ED uses the Australian National Triage Scale (Table 1). This is where patients are categorised on arrival to the department into one of five categories according to the triager's assessment that the patient should receive medical care within a pre-determined timeframe. A Triage Clinical Pathway had been included as an appendix for further clarification of the triage process (see Appendix 2).

Table 1
The Australian National Triage Scale

| National Triage Scale | Treatment Acuity | Numeric Code |
|-----------------------|------------------------|--------------|
| Resuscitation | Seen immediately | 1 |
| Emergency | Seen within 10 minutes | 2 |
| Urgent | Seen within 30 minutes | 3 |
| Semi-urgent | Seen within 1 hour | 4 |
| Non-urgent | Seen within 2 hours | 5 |

(From Mitchell, 1999)

Once initial assessment has been completed the triage nurse is required to regularly reassess the patient until they are accepted into the care of another nurse or doctor. The regularity of this assessment corresponds to the initial triage code assigned by the nurse. For example a patient with a triage code of three should be assessed every thirty minutes. This is to detect any change in the patient's condition that may result in their triage code changing. The triage

nurse should also provide basic first aid (sling, ice, elevation of injured limb) and is able to administer basic analgesics (paracetamol and ibuprofen) if required.

Definitions of terms/concepts

It is important to have some understanding of the terms and concepts that are being explored in this project. Entire books and courses of study have been devoted to determining an understanding of pain, and people's responses to it. It is a complex concept that will only briefly be described here.

The definition of an analgesic is also defined here, with some exploration of how the terms pain relief and pain killers can be used interchangeably. Help-seeking behaviour has been widely researched and there are many reasons as to why people access emergency services rather than primary health care services.

Pain

Attitudes to pain have changed significantly over time (Tebbe-Grossman, 2006) and the experience of pain is a topic that has been extensively researched throughout medical, nursing and psychological literature. It is a broad topic that ranges from the culture of pain (the way in which society shapes the meaning and treatment of pain), the words and terminology associated with pain, differences in responses related to gender and age (Bendelow, 1993; Chambers, Reid, McGrath & Finley, 1997; Monsivivais & McNeill, 2007; Noble et al., 2005; Vallerand & Polomano, 2000).

Pain is a warning sign that something is wrong but it is often difficult to define or measure as people vary as to how much pain they can feel or tolerate (Jackson et al., 2005; James & Hardardottir, 2002; Koutantji, Pearce & Oakley, 2000). Other authors have found that culture shapes the norms, values and beliefs of people and this has a large part to play in their response to pain and therefore their beliefs about analgesics (Wong & Chan, 2008). Given that an individual's response to pain is so personal, research in the area becomes quite complex.

Definition of Pain

Three systems interact to produce pain; the sensory/discriminative system, the motivational/affective system and the cognitive/evaluative system (DeFriez &

Huether, 2008). The sensory/discriminative system processes information about the strength, the intensity, and the temporal and spatial aspects of pain. This system is the one that results in individuals abruptly withdrawing from painful stimuli. These sensations are mediated through the afferent nerve fibres (neurons that transmit sensory information from peripheral sensory receptors to the central nervous system), the spinal cord, the brain stem and the cerebral cortex. The cerebral cortex is responsible for sensing and interpreting input from various sources. It maintains cognitive function, such as thinking and understanding language and interprets various sensory functions such as hearing, vision and touch (DeFriez & Huether, 2008).

The motivational/affective system determines individuals conditioned or learned behaviours in relation to pain. These are mediated through the limbic system and the brain stem. The limbic system is a group of structures that mediate emotions through complex connections in the prefrontal cortex (Sugarman, 2008).

Through the cognitive/evaluative system an individual's interpretation of appropriate pain behaviour is determined and this is learned through life experience and cultural practices. This system can "block, modulate or enhance the perception of pain" (DeFriez & Heuther, 2008, p. 305). Fins (1997) writes that people each have a "personal history that will richly inform his or her behaviour once ill" (p. 169). In this way responses to pain are determined by previous experiences.

One of the best known definitions of pain within the health sector and one which has become a mantra within the medical profession is that 'Pain is whatever the patient says it is'. This definition was developed by Margo McCaffrey, a registered nurse, who has worked extensively in improving the management of patients in pain. Heuther and McCance (2003) write:

"All definitions of pain suggest that it is a complex phenomenon composed of sensory experiences that include time, space, intensity, emotion, cognition and motivation ... it is uniquely experienced by each individual ... it cannot be

adequately defined, identified, or measured by an observer”
(p. 329).

It is this complexity that makes all study in the area of pain difficult. One needs to take on a multi-faceted approach for pain not only impacts on a person's physical functioning, it also has the potential to impact on their psychosocial functioning as well (Kastanias, Snaith & Robinson, 2006).

Measurement of pain

Even given the above definition, there exist several psychometric tests that set out to measure/quantify pain. Noble et al. (2005) researched the development of the measurement of pain over the last fifty or sixty years. They write of the development of standardised questionnaires to determine the characteristics of pain, the emotional impact as well as other dimensions. Many of these pain measurements focus on the experience people have with chronic pain such as the Pain Assessment Battery Research Edition (Eimer & Allen, n.d.) or the Psychosocial Pain Inventory Revised (Heaton, Lehman & Getto, 1985). Perhaps the most frequently used and most often cited pain assessment tool is the McGill Pain Questionnaire (MPQ) (Boyle, 2008).

The MPQ was not designed to specifically look at people with chronic pain as many other assessment tools do. It is inclusive of those with acute pain and is used to look at the qualities of pain and to measure the dimensions of pain that are meaningful to people (Melzack, 1975).

Pain scales

As has been mentioned earlier, only patients can accurately assess and describe their pain. However, it is important that this information is given to health professionals to help them deliver care responsive to patient needs. Various pain assessment scales have been developed to help patients verbalise their pain in clinical settings. These pain scales include non-verbal scales for use with children, patients that cannot speak, and those who do not understand the language in which the assessment is taking place. These tools are most often used to determine a baseline for pain, determine the need for intervention, as well as to determine the effectiveness of interventions (Smeltzer & Bare, 2000) and their use has become routine in many clinical settings (Noble

et al., 2005). The numeric rating scale that was used in this project is described in more detail in Chapter 3.

In conclusion, there are many ways to measure pain. Hadjistavropoulos and Craig (2002) write that self report measures of pain capture “expressive pain behaviour that is under the control of higher mental processes, whereas observational measures capture behaviour that is less subject to voluntary control and more autonomic” (p. 551). Observational means of assessing pain require the observer (or health professional) to look at facial expressions, body posture, movements of the patient, interactions with others, vocalisations and so on (Morello, Jean, Alix, Sellin-Peres & Fermanian, 2007). Recent research has begun advising health professionals to use combined methods of pain assessment that is, self-report and observational, to determine pain levels in patients (Hadjistavropoulos & Craig, 2002; Hall, 2007).

Analgesics

Much of the literature uses different words for similar concepts. Analgesia is defined as a lack of pain without loss of consciousness and, an analgesic is defined as relieving pain or a drug that relieves pain (Bullock, Manias & Galbraith, 2007; Lilley, Harrington & Snyder, 2005). However, the words analgesia and analgesic are used interchangeably throughout the literature as are the words pain relief, pain medication, and pain killers.

Over-the-counter analgesics

Differences exist between prescription medicines, restricted medicines, pharmacy only medications and over-the-counter (OTC) medications. Prescription medicines are those that can only be prescribed by a registered prescriber such as a doctor, dentist, or nurse practitioner and be dispensed by a pharmacist. Restricted medicines can be bought without a prescription but must be bought from a registered pharmacist and a record must be kept of the sale. Pharmacy only medications can only be bought in a pharmacy but do not need to be sold by a pharmacist. OTC's are those medications that can be bought from a supermarket, petrol station or dairy and are not classified under any Medicines Regulations. (Medsafe, 2008). For the purposes of this project I will only focus on people who did not take common OTC analgesics such as paracetamol, ibuprofen and/or aspirin.

It is also worth noting here that these common analgesics, indeed most medications, are known by many different names. A generic name of a medication is the shortened or simplified name of the chemical name (Bullock et al., 2007). This medication can be sold by different companies and is therefore sold under different brand or trade names. For example paracetamol is a generic name (derived from the chemical name para-acetylaminophenol) and is sold throughout the world under different trade names such as 'Panadol', 'Tylenol' and 'Setamol' (Bullock et al., 2007).

Help-seeking behaviour

Help-seeking is defined here as the person making a decision that something is wrong and that some sort of professional intervention is required. This is a complex interplay between the individual needing to recognise that there is a problem, deciding whether to deal with the problem themselves or whether to seek professional care. This can include care from a variety of sources either biomedical (for example a doctor, pharmacist or nurse) or more alternative sources such as a chiropractor, naturopath or reflexologist. This decision making process is based on patients attitudes, their general health status, and their ability to pay for services (Sharma, Hass & Stano, 2003).

Overview

Research into the use of OTC's and ED use has been limited. Fosnoct, Swanson, Donaldson, Blackburn and Chapman (2003) found that patients in severe pain were more likely to have taken pain medication before accessing health care from an ED than those with milder pain. Elderly patients and those that had pain for over eight hours used pain medication more often than younger patients did and, more often those who had pain for a shorter duration. Fosnoct et al. (2003) found that forty-four percent of the people presenting to the ED had taken some form of pain medication prior to arrival. Cham, Hall, Ernst and Weiss (2002) concluded from their own work that many of the patients accessing emergency services use OTC's. This, however, is in contrast to what other studies have found with presentations at ED's without prior use of analgesics between thirty-nine and eighty-one percent (Corbally & Gallagher, 2006; Nicol & Ashton-Cleary, 2003; Singer, Garra, Chohan, Dalmedo & Thode, 2008).

Much of the research has come from a biomedical stance – firmly set in the quantitative arena. Bendelow (1993) writes that health research has been dominated by Western medicine which divides the mind/body and emotion/sensation. Measures such as pain scales fail to “transcend the mind-body dualism and limit how pain is defined” (Bendelow, 1993, p. 288). Though this research was completed over fifteen years ago much of what Bendelow writes about still has relevance today. This quantitative dominance in the literature prompted me to approach the topic in a more qualitative way.

The focus in the literature is also on medical/pharmaceutical interventions that patients implement. Studies have shown that many people that present to ED's have used alternative therapies/interventions. Rolniak, Browning, MacLeod and Cockley (2004) found that there was a high use (forty-seven percent) of complementary and alternative medicine (CAM) use in patients presenting to an urban ED and recommended that patients should be routinely questioned about their use. Nicholson (2006) found that the use of CAM is significant in New Zealand patients presenting to ED's. Though not originally in the research question several participants mentioned alternative methods of coping with pain and therefore it is briefly mentioned here.

Chapter summary

There is a lack of in-depth research to help understand the reasons people attend emergency services and what their expectations of care are. Attitudes to OTC medications and analgesics have been researched but how do these attitudes impact on expectations of care?

This chapter has explored the context in which this piece of research takes place. The wider context of the NZ health system has been described as well as the more localised context of the Wellington ED. Pain, analgesics and help-seeking behaviour have briefly been defined and the process of triage has been explained. In Chapter Two the literature relating to beliefs about analgesics is explored, as are patients' reasons for attending ED's, attitudes and beliefs about pain and analgesics, the use of OTC analgesics and help-seeking behaviour.

The attitudes that people have toward analgesics determines their use. This research has the potential to raise the awareness of all health practitioners about patient's attitudes towards pain and analgesics and to understand the rationales behind patient's behaviours. By understanding people's attitudes towards analgesics and their expectations of emergency care, health professionals can shape patients discharge education/information to best ensure concordance and improve patient outcomes.

Chapter Two

Literature Review

In exploring the questions 'What are patient's attitudes to analgesics? Why don't they take them and what do they expect from emergency health care services?' one needs to look at several concepts and behaviours. The behaviour/s in question involve a complex interplay of attitudes to pain, attitudes to analgesics, attitudes and behaviours around OTC's, help-seeking behaviour and expectations of care. This chapter is a critical overview of recent and significant literature in these fields.

A literature search was conducted using Proquest, PubMed, EBSCOhost, ScienceDirect, and Ovid using journal articles and books from the databases offered through Massey University and Whitireia Community Polytechnic. A key word search strategy was used however, deciding on which key words to use was difficult. I started with the words pain, pain relief, pain medication, pain killers, and analgesics. These words yielded thousands of results but were limited by combining them with searches under the key words of emergency, emergency department, acute, OTC, non-prescription, help-seeking, and access to care. Some further results were gained when looking at age, culture and gender differences in pain perception.

This reviewed literature has been divided into several different categories. Though the topic focuses on analgesics one cannot really investigate this without having some understanding of people's attitudes to pain. Therefore this has been explored. Attitudes to analgesics have been divided in the literature between prescription and non-prescription (or OTC) analgesics. The focus in this chapter is on OTC's. Once this has been explored help-seeking behaviour needs to be discussed. That is, why is it that people seek help from health services and in particular emergency departments? Finally, some research has looked into expectations of emergency care and this will be discussed.

Chronic pain versus acute pain

Much of the research that is conducted in the areas of pain and pain management focuses on chronic pain. Chronic pain has been defined as pain that has lasted longer than six months, or pain that has lasted longer than the expected time for recovery (Curtis, Kolotylo & Broome, 1998). Unlike acute pain which serves a protective purpose, chronic pain has no useful function. When limiting the literature search to acute pain most of the results that emerge are related to post-operative surgical pain, or the prescription and/or administration of post-operative analgesics by health professionals. When the search is further refined to only look at ED's and acute pain, the majority of the results focus on the prescription and administration of analgesics by doctors and nurses, not the behaviours of patients.

Attitudes and beliefs about pain

Pain is an indication that something is wrong within the body and many people believe that pain needs to be tolerated until the body heals itself. In contrast to this, is the belief that pain is not at all beneficial, interferes with life and therefore needs to be managed until the body has healed. The underlying belief that someone has about pain – will often determine how he or she responds to it.

Beliefs about pain are explored in great detail by Dormandy (2006) and include how these beliefs have changed throughout history. Historically there was a belief that pain was God's retribution for sins and needed to be endured. People relished being selected by God for the testing of their faith and their ability to conquer or survive their suffering. In today's society, however, there is "growing impatience with suffering" (Dormandy, 2006, p. 591) and a belief that pain does not and should not be endured and all attempts should be made to alleviate it.

This view may be reflected in the dramatic rise in the pharmaceutical industry over the last few years. Depending on which conspiracy theory one believes in, it is unclear whether this rise is reflective of consumer demand or whether consumer demand has increased through clever marketing and public manipulation. However, the income generated for large companies such as GlaxoSmithKline that manufactures common OTC medications, including Panadol, is huge. Annual sales of all OTC's continue to rise and sales of

Panadol rose by nine percent in the third quarter of 2008 to a total of £82 million (GlaxoSmithKline, 2008).

Conrad (2005) writes a fascinating article that looks at the concept of medicalisation and the impact that both consumers and pharmaceutical companies have had on the process in recent years. He states that though much of the literature depicts the medical profession and interest groups as main proponents of medicalisation, he believes that the advent of biotechnology, in particular the pharmaceutical industry, has meant an increasing commercial and market driven focus to medicalisation. He writes “drug companies are having an increasing impact on the boundaries of the normal and the pathological, becoming active agents of social control” (Conrad, 2005, p. 11). Within the NZ context, Hoek and Maubach (2007) write that due to direct-to-consumer-advertising many people are choosing to “adopt pharmaceutical solutions to health problems rather than implementing lifestyle changes, such a losing weight” (p. 60).

There have been many studies that have looked at people’s attitudes to pain and, as has been mentioned in Chapter One, many of these studies have resulted in pain measurement scales. Yong, Gibson, Horne and Helme (2001) developed a Likert-type scale for measuring attitudes to pain. It was developed to specifically examine the constructs of stoicism and cautiousness relevant to pain perception. This questionnaire was administered to healthy individuals which is of significance given that much of the literature focuses on those with chronic pain or those that are experiencing pain post-operatively. As I was expecting to be interviewing patients that were experiencing pain as a result of trauma I thought the findings of this study would be quite relevant. What they found was that older people were less likely to report pain and were less sure that what they were experiencing could be considered pain. Yong et al. (2001) partially attributed this to changes in sensory function however it could also be related to previous experiences impacting on present perceptions.

Adams and Field (2001) write that an individual’s perception and response to pain is mediated by many psychological factors that include “cultural background, previous experience, and social environment ... their gender,

personality and emotional state" (p. 903). Social learning theorists believe that individuals learn how to interpret pain and how they should respond to it by observing others. Responses to pain are therefore initially learnt within the family and the way in which ones parents respond to their own pain (and the pain of their children) has considerable importance (Bostrom, 1997).

Finding a meaning for pain provides individuals with a way of coping with pain. Glenton (2003) discusses the interesting concept of a need for people to 'legitimise' their pain, find a cause or get a diagnosis. Her research quite specifically focuses on people with chronic back pain however, I believe issues raised in her article have relevance to people even in acute pain. By accessing a health care facility people are taking an ownership of their pain and 'showing others' that they are prepared to take an active role in making themselves better (Glenton, 2003).

In this light one needs to think that by having a legitimate reason for the pain, by which I mean a diagnosis, a patient will be able to cope with the pain better. Anecdotally, as a triage nurse you often find people presenting with a painful and/or swollen ankle due to trauma and unable to weight bear due to pain. However, once an x-ray confirms no evidence of a fracture the patient is able to walk again – even without administration of analgesics or aid of crutches. I believe that there exists a need to legitimise pain and that with a diagnosis of no major injury/trauma, people will tolerate their pain.

Allcock, Elkin and Williams (2007) looked at patients expectations of care from a pain clinic following referral and write that patients' beliefs about their pain have been shown to have a significant impact on their experiences and their treatment outcomes. Their study has relevance in that the participants were asked about their expectations of care prior to actually receiving any treatment and it was found that most of their participants found it difficult to articulate what they wanted from the pain clinic because they knew nothing about it. Most replied that they wanted treatment for the pain. Public perceptions of emergency department care are probably greater than that of a pain clinic given the exposure, however unrealistic, of popular television programmes such as Shortland Street, ER and Casualty. Allcock et al. (2007) found that three sets of

pain beliefs emerged. Participants were concerned that they did not know the cause of their pain therefore it was important to them that a cause for the pain be established. A second theme was that without a diagnosis other people did not believe in the pain. What may be of some significance is that several participants thought that the prescription of analgesics was “fobbing off” and that “only prescribing painkillers” was inadequate (p. 252). Allcock et al. (2007) write that “it is important to consider patients’ beliefs about their pain as these are likely to influence their perceptions and expectations of treatment...” (p. 253).

Perceptions about pain have also been found to differ between men and women. Bendelow (1993) found that social expectations of the way that men deal with pain is different to the way women are expected to deal with pain. Both men and women believed that women had a “natural capacity to endure pain” (Bendelow, 1993, p. 88) and that experiences of childbirth and period pain were related to this. Of particular interest here is the experience of childbirth, which is painful. However, the pain of childbirth can be viewed as a positive experience (Bendelow, 1993). This research was done over fifteen years ago but recent work by Bendelow has yielded similar results (Bendelow, 2006).

As I have written before that attitudes and beliefs about pain are complex and multifaceted. One needs to take into account the age of a person, the gender, previous experiences in feeling pain and in treating pain, their culture, social environment and emotional state. Adams and Field (2001) include the social context within which an injury occurs has an impact on the experience of pain:

“The social context in which an injury occurs and hence the meaning of the situation may have a profound influence on the patient’s interpretation and experience of pain. Patients undergoing elective surgery ... report less pain than those involved in a sudden accident ...” (p. 909).

Attitudes and beliefs about analgesics

Adams and Field (2001) cite research that finds that peoples beliefs about the effectiveness of treatments directly influences the actual effectiveness of those

treatments. This is of relevance in that as a health professional I have heard many people state that they did not want paracetamol as they do not believe it is an effective analgesic.

A lack of literature into the emotions people have towards pain medications (and therefore the potential barriers to people using pain medications if prescribed), resulted in the Mayday Fund which looked at people's assumptions about pain and its treatment (Bostrom, 1997). Their results showed that people had a fear of taking medications as it could result in addiction or dependence. People also thought that if a medication was used frequently or too often, it would become less effective. Other findings were that people believed that alternative techniques such as relaxation and exercise were as effective as analgesics in relieving pain.

Thomas (2007) identified patient related barriers to effective pain management within ED's. She lists the fear of addiction, trying to be a 'good' patient, a desire not to bother nurses and "patients not taking responsibility for their illness/recovery (adopting the sick role)" (p. 43) as reasons for patients not taking/receiving analgesics. Similarly, Monsivais and McNeill (2007) write that "research on medications of all types shows that concerns about dependency, adverse side effects, and whether the medication is really necessary all play an important part in determining whether the patient will take medications as prescribed" (p. 70). They continue to say that the influences of society on the health care system and the cultural background of a patient have a profound influence on attitudes and beliefs to pain medication.

Nicol and Ashton-Cleary (2003) took a qualitative look at why people did not take analgesia prior to attending an ED in the United Kingdom. Answers included a belief that pain should be tolerated and a dislike to taking pills or tablets. What was interesting was that though the study objective answered the question 'why do people not take analgesics' it raised another issue of what are the expectations of patients in pain, who do not want to take pain relief?

What was acknowledged by Nicol and Ashton-Cleary (2003) was the lack of investigation into alternative methods, or non-pharmacological methods, of pain

relief which may have shown that patients were active in treating their pain but not with medication. Vallerand, Fouladbakhsh, and Templin (2003) state that forty-two percent of adults in the United States experience pain daily and complementary therapies, such as herbal products, chiropractic treatments and prayer/meditation are used by approximately seventy-six percent of adults. Bostrom (1997) found that many people find that "relaxation, massage and exercise are often effective in relieving pain" (p. 166) and they would use these natural pain relief techniques before trying pharmacological analgesics. This leads me to wonder whether ED staff should be asking "What have you done for your pain?" rather than "Have you taken pain relief?"

Use of Over-the-Counter analgesics

Research into the use of OTC analgesics is wide and varied focusing on their use with children (Lagerlov, Helseth & Holager, 2003); among adolescents (Chambers et al., 1997) through to their use amongst the elderly (Amoako, Richardson-Campbell & Kennedy-Malone, 2003). Amoako et al (2003) state research has shown that health care users self-treat four times as many health problems, than health practitioners do; that sixty to ninety-five percent of all illnesses are initially dealt with by self-care and this includes the use of OTC's. They found the most commonly used medication was for pain relief with ninety percent of the participants using some form of analgesic (Amoako et al., 2003).

Turunen, Mantyselka, Kumpusalo and Ahonen (2004) also found that the most common way that people managed their pain was through the use of OTC analgesics and that it was the location of pain which determined whether analgesics were used or some other form of pain relief such as exercise. They built on this study and confirmed that people frequently use analgesics especially if they had chronic pain or high pain intensity (Turunen, Mantyselka, Kumpusalo & Ahonen, 2005).

Wazafy, Shields, Hughes and McElnay (2005) looked at public opinion and perceptions about OTC drugs. The quantitative study consisted of a survey that asked people about attitudes to and use of OTC medications. Results showed that approximately one third of people surveyed bought OTC medicines (not necessarily analgesics) and that the majority followed the instructions on the

product. These results may not be comparable to New Zealand however, as NZ is one of the few places where you can buy medicines from the supermarket. The ease of access must make some impact of the attitudes and beliefs that people have about medicines.

Cham et al. (2002) attempted to determine people's knowledge and use of over-the-counter pain medications. The authors believed that age, education and access to medical care influenced patients awareness of the interactions and side effects of analgesics. This study was relevant in that it surveyed ED patients that presented to the triage desk. They found that even though a significant number of people used OTC analgesics, such as paracetamol and ibuprofen, prior to presentation, most had very little understanding of the side effects and potential harm of these medications (Cham et al., 2002). They also found that the use and knowledge of the different analgesics differed between age and gender. For example, young people used more ibuprofen than the elderly and men used less ibuprofen than women.

Fosnoct et al. (2003) conducted a quantitative study was to determine the frequency and types of analgesics taken by patients prior to presenting to an ED. They looked to see differences existed based on pain intensity, duration of pain, gender, age and race. They found that patients in severe pain were more likely to take analgesics before arrival. Elderly people (defined as those over the age of fifty-five) were also more likely to have taken medication than younger people. Those that had pain for over eight hours were also more likely to have taken medication than those who had pain for a shorter duration. They found no difference in medication use between genders or races. Forty-four percent of patients took analgesics before attending the ED and the authors concluded that many patients do take some form of medication before attending.

Other literature has found that fifty-six percent of patients presenting to ED used OTC (Heard, Sloss, Weber and Dart, 2006) however, this is contrast to what Corbally and Gallagher (2006) found which was that up to eighty-one percent of patients do not take analgesics before attending an ED. Corbally and Gallagher (2006) cited research that showed that there is a perception among the general

public that OTC analgesics are not 'real medicines' and that there will be something stronger available in the ED.

One of the underlying assumptions in much of the research presented here is that patients should be taking analgesics before presenting to ED for treatment. As has been mentioned earlier alternate forms of analgesics have not been investigated in any great detail in relation to patients that access emergency care.

Help-seeking behaviour

Research has looked into the determinants of self-referral to doctors and other health care professionals and shows that the reasons that people access health services are wide and varied (Cameron, Leventhal & Leventhal, 1995; Sharma et al., 2003). Fish Ragin et al. (2005) found five distinct reasons that patients accessed emergency services and identified them as medical necessity, convenience, preference as a source of care, limitations of insurance and affordability.

In their study Fish Ragin et al. (2005) used a demographic mix of patient populations and ensured that only those patients that had self-referred (as opposed to being sent in by their general practitioner or other health care professionals) were included in the study. I believe one of the limitations of this study was its quantitative design. It is interesting that something as complex as reasons for visiting an ED can be quantified into twenty-one statements. The authors give the example of a statement "This is a medical emergency" and ask patients to 'strongly agree, agree or disagree' with it. A statement like that is open to many different interpretations and two patients presenting with the same conditions may have different perceptions as to whether it is an emergency or not.

Fish Ragin et al. (2005) stated that many people prefer to receive care from a hospital emergency department rather than a primary care giver. Reasons for this included the ease of access to other diagnostic tests that may be required (such as radiology or laboratory services), as well as a belief that the care received was of a better standard than offered elsewhere. Similarly, Moll van

Charante, ter Riet and Bindels (2008) found that reasons for patient to seek out care from emergency services rather than primary care services was a belief that ED's had diagnostic equipment/services more readily available than local GP's and a belief that medical staff at ED's were better qualified than GP's.

Hider, Helliwell, Ardagh and Kirk (2001) aimed to determine the characteristics of patients attending an ED in a large city within NZ. They found that children (younger than 14 years) and the elderly (over 65 years) were the most frequent visitors during week days. This changed in weekends when attendance by younger people was more common. Reasons for attending related to medical and surgical conditions, psychiatric problems and physical injuries.

Severeijns, Vlaeyen, van den Hout and Picavet (2004) investigated whether people who catastrophise about their pain have a higher rate of accessing health services, of using analgesics and of taking time off work due to their pain. They define pain catastrophising as "an exaggerated negative orientation toward pain" (Severeijns et al., 2004, p. 49) and state that this can lead to a hypervigilance to bodily sensations. This hypervigilance leads to increased access to health services.

Reasons for accessing health services are as complex as those for taking analgesics. People often wait and see what happens in the initial stages of symptom development. They wait to see if things get better or worse before making a decision to seek medical care (Cameron et al., 1995). Quah and Bishop (1996) found that a person's culture, and their orientation within that culture, influences illness cognition, interpretation of symptoms and help-seeking behaviour.

Shi, Langer, Cohen and Cleeland (2007) found that thirty-one percent of their general population sample had experienced some form of pain within the previous two weeks and of those people, seventy-five percent had accessed some form of medical attention. Seeking help from a health professional was the main means of achieving pain relief with alternative interventions such as OTC's, bed rest and prayer as secondary strategies.

Addis and Mahalik (2003) write that men have different help-seeking behaviours to those of women and that there is a wide body of research that supports the notion that men do not like to seek help from health professionals. This relates to the way men think friends and colleagues may react when they find out that help has been sought as well as a perceived need to be able to reciprocate in some way.

Expectations of care

Thomas (2007) found that pain is the most common complaint on attendance in ED's therefore one could assume that analgesics would be what patients wanted from emergency services. Beel et al. (2000) found that eighty-eight percent of patients presenting to an ED wanted analgesics for fractures and that twelve percent of patients declined analgesics. They found that the group of patients did not decline analgesic because of a lack of pain but they did rate their pain level at a much lower level than those requesting analgesics.

White (2007) found that the most effective intervention for pain relief in an ED was definitive treatment followed by continuity of care (relating to follow up appointments and so on). The least important intervention cited by respondents was analgesics. The conclusion she reached was that even though most people who present with non-life threatening conditions are in pain, most people do not need analgesics to relieve pain.

In their study Singer et al. (2008) found that nearly half the patients presenting to their ED in pain, did not want analgesics. Though their average pain levels were lower than those of patients requesting analgesics, in many cases pain levels were in the moderate to severe range. The authors also did a statistical analysis of reasons that people did not want analgesics and found that people had already taken analgesics at home, that pain was tolerable and that people wanted to remain alert.

Fosnoct, Heaps and Sanson (2004) write that patients' expectations for pain relief in ED's have not been fully evaluated. They found that expectations for pain relief may be independent of the presenting injury or illness and suggest that these expectations have been predetermined by previous pain experiences

and any prior treatments that patients may have received in any health care services. As mentioned earlier television representations of emergency services may also influence expectations of care.

Chapter summary

This is a very complex field of study. Much of the literature focuses on people with chronic pain concerns or on acute post-operative pain. From my readings, I have concluded that there are many reasons people access health care systems and probably just as many reasons that they do not. The perceived need for care is the obvious theme however; this perceived need does not always tie in with the views of health professionals (Richardson et al., 2006). There are reasons and justifications for taking analgesics and many for not taking them. The overriding issue with all of the research above is can it be used to help, explain or understand the health behaviour of people within the context of NZ society? Given the large influence that Maori and Pacific cultures have for many in NZ, either directly or indirectly, I believe there would be different research outcomes if this research were conducted here. Some research has already been conducted in the NZ context. Nicholson (2006) looked at the prevalence of CAM in a NZ ED and included traditional Maori treatments. She found that while a third of her sample population had used some form of CAM only seven percent of that third had used traditional Maori therapies.

There is a lack of in-depth qualitative research attempting to understand the reasons that people do not take analgesics and why they access emergency services. Further investigation is required into people that present to an ED but do not like taking analgesics, or do not “believe” in taking pills, or think that pain should be tolerated. This work needs to be of a qualitative nature – asking questions about patient’s attitudes to analgesics and what they expect from the emergency health care.

Chapter Three

Methodology

In choosing a methodology one needs to be aware that every piece of research is unique and therefore calls for unique methodology. Bryman (as cited in Pidgeon & Henwood, 1997) writes that the choice between qualitative and quantitative approaches should rest entirely on the problem under investigation and that some enquiry lends itself to qualitative methodology and other enquiry to a quantitative methodology.

Much of the research within the area of pain and help-seeking behaviour is based firmly within a biomedical model. Baum (1995) writes that the biomedical model is "... based on the belief that phenomena can be reduced to their constituent parts, measured and then causal relationships deduced" (p. 461). This is a quantitative approach to discovery.

Because of the large amount of quantitative research in the field of pain, pain beliefs and pain management, I believed that a more in depth, qualitative approach would better suit the aims of this project. Baum (1995) writes of the increasing acceptance of non-quantitative research particularly in research designed to increase understanding of health.

Rather than starting with a hypothesis as in quantitative research, qualitative research often starts with a question of 'What if ...' or 'Why'. O'Neill (2002) writes that the focus of qualitative work is on how participants make sense of their world, followed by the researcher trying to "make sense of the sense they make of their world" (p. 192). Chenail (1995) writes "Qualitative research is the practice of asking simple questions and getting complex answers" (para. 45).

This project initially started out as a research proposal for a health psychology paper and from that grew into the current project. Consultation with colleagues and various groups ensued and ethical approval was sought through the Central Regional Ethics Committee. This process will be described.

The setting in which this project was undertaken and the selection process and criteria for participants will be detailed. Data was collected using a semi-structured interview process and interviews were audio recorded. The process of listening to these recordings and extracting themes will be described.

The qualitative research approach

Much of the research conducted in the area of pain is firmly based in the quantitative arena and, as described in Chapter One, there are many research tools developed to investigate the way that people interpret pain, how they rate pain and what they believe about pain. If you include in this review of available tools, the concepts of attitudes and/or beliefs about pain relief, pain medications, and pain killers, there is a vast array of information that can be gathered from potential participants. However, much of the information gathered by these tools is numeric or quantitative. They fail to allow people any scope to answer questions in ways that can fully describe or explore what they think, the way they think or how they behave.

Debates have existed about appropriate methodology in the study of health and health problems. Tolich and Davidson (2003) write that “no one research method is intrinsically and universally better than any other ... particular problems demand particular solutions ... research should always be tailor-made” (p. 21). I thought that this area of study needed a qualitative approach so that something new could be added to the topic.

O'Neill (2002) writes very descriptively that there still exists a “... tension between two paradigms in psychological research: quantitative and qualitative” (p. 190). He describes this tension using the metaphor of tectonic plates. These plates that float upon the earth's surface, move incredibly slowly yet result in major development of mountains, and contribute to continental drift. Sudden movement in these tectonic plates result in earthquakes which again, can result in major geological transformations of landscapes. He likens these geological transformations, or earthquakes, to the impact that qualitative work has had in psychology. Initially viewed as very poor cousins to quantitative methodologies, qualitative methodologies are becoming accepted and

respected and have the potential to make a significant impact to the broad field of psychology.

There are many different methods that can be used under the 'umbrella' of qualitative research. However, according to Streubert Speziale and Carpenter (2003) all qualitative researchers emphasise certain characteristics to their research. These include a belief in multiple realities, a commitment to participants' viewpoints and an acknowledgment that the researcher is a participant in the research process. Research should be conducted in a way that "limits any disruption to the natural context of the phenomenon of interest" (p. 16). In this light, this research project was conducted in a way that would have minimal impact on participant's health care experience.

Aims of the study

The attitudes that people have toward analgesics determines their use. This exploratory study aims to discover patient's attitudes towards pain and analgesics and their expectations of emergency care and, has the potential to raise the awareness of all health professionals of the rationales underlying patients' behaviours. By understanding people's attitudes towards analgesics and their expectations of emergency care, health professionals can shaped patients discharge education/information to best ensure concordance and improve patient outcomes.

Ethical considerations

Ethical approval for this project was gained through the Central Regional Ethics Committee (Appendix 3). Traditionally ethical issues have focused around the topics of informed consent, the right to privacy and protection from harm (Fontana & Frey, 2000).

Informed consent

All people that take part in research are required to give informed consent. This means that they must be informed about the research processes and the risks and benefits of the research. They must also be given the opportunity to ask questions and advised that they can withdraw from the research at any stage (Snook, 2003). They can then agree to take part in the research or not.

Roberts (2002) writes that four domains may potentially influence individuals volunteering to participate in research. These are developmental factors, illness related considerations, psychological issues and cultural and religious values and finally, external features and pressures. Of significance to the present study is that research conducted within institutional settings may generate pressures on individuals to participate. This has been addressed by the disclaimer in the Information Sheet that states that the decision to participate does not impact on care.

Information was given to participants of this research project via the Information Sheet provided by the triage nurse at initial presentation (see Appendix 4). After they read the information they were approached and asked if they would be willing to participate in the project. All patients approached were required to sign a Consent Form (Appendix 5).

Privacy

One of the major issues in this study was that of privacy. Respect for privacy is not just an ethical requirement in NZ but a legal one as well (Coup & Schneider, 2007). Though previous research has been conducted in waiting rooms, concerns were raised by the Ethics Committee about interviewing participants in a public place like the waiting room. Therefore participants were offered a choice of a private interview room to conduct the interviews in to maintain privacy and confidentiality. Through consultation regarding cultural issues, it was deemed necessary that all participants that identified themselves as Maori should only be interviewed in the interview room and not the waiting room. This will be described in more detail later in this chapter.

Protection from harm

Any research should ensure that participants are protected from harm throughout the research process. In particular, research in health is often undertaken with unwell or vulnerable people. The definition of harm is quite wide and does not just refer to the physical harm of medical experiments (Snook, 2008). For example, harm can include damage to self-esteem, public embarrassment or reactivation of forgotten or suppressed memories. There were no anticipated physical or psychological risks to participants in this project. Participants were informed that they could withdraw from the interview process

at any stage with no compromise to care received by the ED. Taking part in the research project did not change the length of time between triage and medical help.

Anonymity and Confidentiality

Anonymity is defined as the inability of anyone being able to identify the participants of a study, and this includes the researcher. This is easier to achieve in quantitative research where researcher sometimes do not meet participants but is often harder in qualitative work where researcher and participant meet face-to-face (Coup & Schneider, 2007).

Confidentiality means that the information provided by research participants cannot be used to identify them and all researchers are obliged to ensure that all data, subsequent findings and publications prevent any recognition of participants (Snook, 2008). This means that a person's name should never be recorded on an audiotape or placed together with transcripts of these audiotapes. If a transcriber is to be used, that is someone other than the researcher, then the participants need to know this and be assured that the transcriber will sign a confidentiality declaration (Coup & Schneider, 2007).

Anonymity was not possible in this situation as participants were required to sign a consent form and I had access to their names. However, confidentiality was assured. Consent forms were kept separate from gathered data, audio recordings were transcribed by me, and the audio recordings were kept on file on a password protected computer.

Ethics approval

Prior to the research going ahead approval had to be gained from the ED at C&CDHB. This involved submitting a written proposal to the research team, which met on a monthly basis. This approval was first gained in July 2007 however, due to the long delay between gaining this approval and actual commencement of the project further approval needed to be gained from a new team leader in June 2008. Once this was obtained, I was able to ask for approval for the project, from the Central Regional Ethics Committee.

Ethics approval for my research was applied for in July 2008. I attended a meeting on the 8th July 2008 and several issues were raised by the committee. These included that patients in pain may not be able to give informed consent to participating in research and privacy issues related to interviewing participants is a waiting room. These were addressed and clarified and approval for the project was finally gained on 29th October, 2008.

Cultural considerations

In keeping with the principles of the Treaty of Waitangi consideration needed to be given to those participants that identified themselves as Maori. According to the Health Research Council of New Zealand (2008) any research that involves Maori as participants needs to consider several points. They write that following discussion with Maori groups the researcher must consider how the research findings will impact on Maori and Maori health as well as what benefits are there for Maori. Though I had spoken with Maori colleagues from my workplace and had included their input into my research design, I was told that I needed to speak with Maori from the iwi in which the research was taking place. Evidence of Maori consultation was finally obtained through meeting with a representative of the Research Advisory Group – Maori (RAG – M) at C&CDHB and a referral to Maori Health Education & Recreation (H E & R Services Ltd).

As a result of this consultation, the following issues were considered. Talking about private issues in public is difficult for Maori and therefore should be avoided wherever possible (see Appendix 6). Maori clients needed to be interviewed in private and whanau support had to be offered to all participants. This means that family members should be able to sit in on interviews if requested by participants and if immediate family members are not available then more formalised services such as Whanau Care Support (as provided by C&CDHB) needed to be contacted and the interview process deferred until they were available.

Potential for role conflict

This issue is addressed here because, as I work as RN in Wellington ED at C&CDHB, there was a potential for a conflict of interest. The Central Regional Ethics Committee also raised issues with the potential role conflict between that

of a researcher and that of a registered nurse, conducting research in my place of work.

As a nurse educator offering supervision to nursing students on clinical placements in ED I had already established strategies for managing dual roles in the area. Though I found it difficult to maintain boundaries of researcher and staff member when the department was busy or short staffed it was possible. To maintain these boundaries all interviews were conducted on days I was not rostered to work. I was very clear that I was working as a researcher and not as a RN. As I was not wearing a nurse's uniform it was relatively easy for the ED staff to remember. Patients known to me, through personal relationships or through frequent previous ED presentations, were excluded from participating.

The advantages to this research being completed by an RN working in the ED were that I had an understanding of the ED processes. Though patients were initially judged as appropriate by the triage nurse, I also had the ability to determine if a patient was an appropriate participant for the project on medical grounds and was comfortable with the process of triage and the use of the Glasgow Coma Scale. I had previously established rapport with the medical and nursing staff and co-operation with the research was easy to establish.

However, if there was an emergency situation that required immediate nursing intervention the Ethics Committee stated that I would be required to provide first aid care, as a member of the public, until other nursing/medical staff arrived.

Design/Approach

A semi-structured interview method was chosen for this research project as it is flexible and allows in depth exploration of issues that may arise through questioning (Gomm, 2008). New questions can be brought up during the interview as a result of what the interviewee says. There is a freedom to ask questions in any order, to follow side issues and tangents and to seek clarification from previous answers. Interpersonal skills can be used to facilitate cooperation and elicit more information.

Demographic information

Information on age, gender, and ethnicity, was gathered, as was the mechanism of injury/cause of pain, and the triage code assigned to the patient by the triage nurse. This information was for descriptive purposes and to allow for between group comparisons such as differences between male and female participants, differences in responses reflective of the age of the participant and/or differences between ethnicities. There was also the potential to determine if level of pain was correlated in any way to expectations of care.

Data Analysis

The purpose of data analysis is to make meaning from the data that has been gathered. Crotty (1998) writes that we make meaning from what we expect to see but that it is possible to “make sense of the same reality in different ways” (p. 47). This means that though several people may be involved in an interaction, the meaning of the interaction may differ for each individual involved. Interpreting data gathered from research can therefore be dependent on the researcher that is analysing the data.

Gomm (2008) writes that when researchers use semi-structured or qualitative interviews much of the analysis occurs during the process of collecting data. The interviewer decides “what questions to ask next, when to speak, when to remain silent and so on” (Gomm, 2008, p. 204). He calls it intuitive data processing and states that it is an important part of qualitative analysis.

Thematic analysis is a flexible method for “identifying, analysing and reporting patterns (themes) within data” (Braun & Clarke, 2006, p. 79). They write that though thematic analysis is being increasingly used within psychology, there is no clear definition as to what it is and how to go about it.

It is important to remember that themes that emerge are part of an active process that the researcher has with the data and Braun & Clarke (2006) write that the researcher always plays a role in “identifying patterns/themes, selecting which are of interest, and reporting them to the readers” (p. 80). Gomm (2008) writes that one needs to be aware that it is possible that data can be

'massaged' by the person doing the analysis so that it shows themes that the analyst is expecting to find or themes that the analyst wants to find.

One needs to have some understanding of what actually constitutes a theme. How 'large' does a theme need to be? Braun & Clarke (2006) write that there are no hard and fast rules as to what proportion of data are needed for a researcher to identify that a theme is present. They write that the researcher must use personal judgement in their analysis and that they should remain flexible.

Inductive thematic analysis is a process of identifying themes without trying to fit them into pre-existing notions or ideas. Similar to grounded theory, themes emerge from the data and may have little relation to the specific questions that were initially asked of participants (Braun & Clarke, 2006). I had preconceived ideas of what participants would be telling me in their responses. These reflected what had been found in previous research such as 'I don't like taking pills', 'I don't want to mask the symptoms' and others which I had heard frequently as a triage nurse such as 'Panadol doesn't work for me'. However, by being aware of these preconceptions during the analysis processes their impact will hopefully be minimised.

Chapter summary

This chapter has described the processes involved in this research project from its inception as a clinically based query and university assignment, through the rationales for undertaking qualitative research in a quantitative dominated arena, through the processes of Maori consultation and ethics approval. The design choice and approach, and the procedures for data collection have been described as well as the data analysis processes. The next chapter will focus on the actual procedures and data collection.

Chapter Four

Method

In the preceding chapter the rationales and thought processes behind the project were described. In this chapter the actual procedures involved in the data collection will be explained. The demographics of the seven participants will be given, and the measurements used in selection are included. Prior to interviewing participants however, I needed to think about how to present myself.

Participants

Study participants consisted of a convenience sample of patients presenting to the ED with a painful condition. As emergency care is available over 24 hours the interview process needed cover several different times over a 24 hour period to ensure an adequate range of participants. Anecdotally, younger people present later at night or during the weekends though this has been supported by work from Hider et al. (2001) who found that during week day's children and the elderly access emergency services whereas young adults tend to use the service after-hours.

Participants were recruited over ten days in a two month period with interviews occurring between the hours of 10 o'clock in the morning and two o'clock in the morning. On two separate occasions I was available to interview participants between 2300 hours and 0230 hours – however, no patients presented that fulfilled the criteria for participation in this time.

Patients were included if they presented with a minor illness or injury, complained about pain or discomfort and refused analgesics when offered them by the triage nurse. Differentiation between minor and major illness and injury was dependant on the triage category the patient was assigned on initial presentation. The triage process has been described earlier in Chapter One. Only patients' assigned codes of Triage 4 (semi-urgent) or Triage 5 (non-urgent) were included as potential participants.

Demographics of participants

This information was gathered for descriptive purposes and for the potential of between group comparisons. It was gathered to provide support for the qualitative aspects of the study.

Pain ratings for the participants ranged from 1 to 5/6. Four of the participants were female and three were male with an age range from 21 years to 62 years. All participants, bar one, identified themselves as European. Participants were given a triage code of 4 (semi-urgent) or 5 (non-urgent).

Table 2
Demographic Information

| Participant | Age | Sex/gender | Ethnicity | Triage Code | Pain rating |
|-------------|-----|------------|----------------|-------------|-------------|
| 1 | 42 | Female | European | 5 | 5/6 |
| 2 | 27 | Male | European | 5 | 4/5 |
| 3 | 36 | Male | European | 4 | 3 |
| 4 | 62 | Female | Fijian/Chinese | 4 | 2 |
| 5 | 38 | Female | European | 4 | 1 |
| 6 | 26 | Female | European | 4 | 2 |
| 7 | 21 | Male | European | 4 | 4/5 |

Presenting injuries were most often musculoskeletal injuries with two participants with wrist injuries, two with foot injuries, one with an ankle injury and one with a laceration to the knee. One person presented with a facial abscess.

Exclusion criteria for participants were those known or identified as under the influence of alcohol or drugs, those known or identified as violent, or in police custody as well as those known or identified with a psychiatric history. Participants also had to speak and understand English. Patients that I knew, either personally or through repeated ED presentations were also excluded from participating.

Participants had to be over the age of 18 years – to ensure they were able to take analgesics without parental involvement. Participants were also required

to give consent to participating in the study therefore only those with a Glasgow Coma Scale (GCS) of 15 were included.

Measures

Participants had to have a GCS of 15 and were also asked to provide a rating for their pain level. These measures and the question guidelines are described.

The Glasgow Coma Scale

This scale is used to assess the level of consciousness (LOC) of a patient based on three criteria of eye opening; verbal response; and motor responses to verbal commands or painful stimuli. Patient's responses to stimuli are recorded as shown in the Glasgow Coma Scale Chart (Table 3). Each response is given a number (high for a normal response and low for an impaired response), and the sum of these numbers gives an indication of the level of consciousness of the patient. The lowest score is three which means that the patient is non-responsive, and the highest score is 15, which means that the patient is alert and orientated.

Reasons for a low GCS vary from alcohol intoxication or overdose; overdose of medications; hypoxia (low oxygenation of tissues), through to mild or severe brain trauma. It was decided that only those with a GCS of 15 were able to make an informed choice of whether to participate in the study therefore the scale was used for exclusion purposes only. All participants had a GCS of 15.

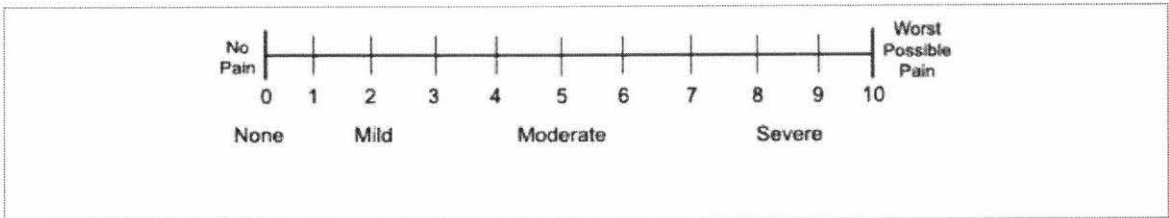
Pain Scale

I also asked participants were also asked to rate their level of pain. As described in Chapter One tools exist to determine patient's level of pain. I used a numeric rating scale to assess participant's levels of pain. This scale asks the patient to describe their pain intensity on a scale of zero to ten (Figure 1) with ten being the worst pain imaginable and zero being no pain at all.

Table 3
Glasgow Coma Scale Chart

| | | |
|-----------------------------|-------------------------|---|
| Eye Opening Response | Spontaneous | 4 |
| | To voice | 3 |
| | To pain | 2 |
| | None | 1 |
| Best Verbal Response | Orientated | 5 |
| | Confused | 4 |
| | Inappropriate words | 3 |
| | Incomprehensible sounds | 2 |
| | None | 1 |
| Best Motor Response | Obeys commands | 6 |
| | Localises pain | 5 |
| | Withdraws from pain | 4 |
| | Flexion to pain | 3 |
| | Extension to pain | 2 |
| | None | 1 |

(from Smeltzer & Bare, 2000)



(From Smeltzer & Bare, 2000)

Figure 1
Numeric Pain Intensity Scale

Question guidelines

Introductory questions were asked of participants as to how the injury occurred, or where the pain was. This allowed the participant to become relaxed and comfortable with answering questions. All participants were asked if they agreed to have their responses digitally recorded.

Participants were asked a series of open ended questions relating to their thought, beliefs and behaviours around pain relief. They were questioned further as to what they expected from emergency care. Due to the nature of

semi-structured interviews each participant was asked slightly different questions, following tangents and side issues that were raised by them from introductory conversations and responses to questions. The question guidelines have been added as an appendix (see Appendix 7).

Procedure

The setting for the study was the Wellington Department of Emergency Medicine, a busy ED. The department sees approximately 45,000 people per year from all ages and a wide range of diverse ethnic, socioeconomic and professional backgrounds (C&CDHB, 2008). On initial presentation all patients are assessed by a registered nurse to determine how quickly they need to be seen by a medical professional. This occurs at the triage desk in the waiting room. Unless requiring immediate intervention, patients are 'linked and clerked' by reception staff (that is logged onto the ED's computer system) and asked to sit in the waiting room to wait for a nurse or a doctor to see them. This wait can be from as little as five minutes up to five or six hours if the ED is particularly busy, overcrowded or short staffed.

The waiting room can sit up to approximately forty patients. There was a television to watch, a children's playroom, and magazines to read while patients waited. A vending machine and cold water were available as well. The waiting room can become quite noisy and is not very private.

Once patients were triaged on arrival to Wellington ED, they were identified as fulfilling the selection criteria by the triage nurse and given the Information Sheet. This detailed research aims, benefits of the study, assurance of confidentiality and so on. It was clearly documented that there would be no impact on waiting time or treatment. Participants were allowed time to read the Information Sheet. I then approached them in the waiting room and asked if they were willing to participate in the research project. Reassurance was given verbally that responses would in no way impact on treatment. Participants were informed that it would be possible for medical and nursing staff to interrupt the interview process if treatment was available to the participant, however, this did not occur and all patients were interviewed well before seeing any member of the treatment team.

Participants were asked if they would prefer to be interviewed in the waiting room or in an interview room. An interview room was available on site and was easy to access from the waiting room however, all participants elected to remain in the waiting room for the interview process. Family/whanau of participants were able to sit in on the interview process if the participants wanted this. All were given a consent form to sign.

Interviews

Seven interviews occurred over several days in a two month period. They were conducted between the hours of 1000 hours and 0200 hours. Approximately fifty hours was spent within this time frame waiting for patients to present that would fulfil the selection criteria.

Partway through one interview the participant decided that she did want some form of analgesic and she asked questions on how and when to take analgesics. Though Fontana and Frey (2000) state that the interviewer should “avoid getting involved in real conversation in which he or she answers questions asked by the respondent” (p 660) and should “feign ignorance” I found that the RN in me could not do this. The patient needed some health education and some analgesics and this needed to be addressed. I stopped the interview, briefly answered her question and stated that she should ask the nurse or doctor that would be looking after her for further information. I also informed the triage nurse that she had changed her mind and now wanted some form of analgesic. This participant’s responses were included in the study.

Data Analysis

The search for themes was divided into two separate sections. The first was looking at participants responses to the question “Why haven’t you taken any pain relief?” The second section was analysis of responses to the question “What do you expect from emergency services?” Following repetitive listening of audio digital recordings I transcribed what was said by participants. I read and re-read transcripts while listening to the recordings. As suggested by Braun and Clarke (2006) I looked across the entire data set trying to find commonalities or themes. I took notes from each interview and picked out key

words that were used by each participant and then looked to see if the same words or ideas had been used by others. If a participant introduced a new word or phrase or theme it was noted and subsequent and previous transcripts were analysed to determine if similar themes existed. In this way several themes were identified and are described in the following chapter.

Chapter Five

Findings

Braun and Clarke (2006) state that determining 'prevalence' of information within data can be determined in two main ways. Firstly, by the number of times *one* person talks about a particular theme and secondly, prevalence can be determined if a theme is talked about by more than one participant. As mentioned in Chapter Three there are no hard and fast rules as to what proportion of data is needed to determine a theme. With this in mind I started my analysis.

The findings in this chapter are presented in the order of questions asked in the interview guidelines. The initial question was related to why participants had not taken analgesics and geared to finding out the rationales behind their behaviours. Subsequent questions related to expectations of emergency services.

“Why haven’t you taken any pain relief?”

Given that participants had not taken any analgesics, and had declined them when offered at triage, the opening question to participants was to determine reasons for not taking analgesics. It was worded differently for all participants depending on what had been said in the introductory session where I introduced myself, gained consent and gathered the demographic information. Participants would often start talking about their experience as soon as I approached them however, this part of the interview was not recorded and therefore not included in the transcripts. In one interview I opened with “So, you normally take pain relief ... what’s different today?” In another interview I started with “Why haven’t you taken any pain relief?” The answers to these questions did seem to fall into certain themes.

Theme One: “It’s not that painful”

The majority of participants stated that the pain they were experiencing was not severe and therefore did not warrant the use of any analgesics. This was a

theme that appeared to cut across all of the interviews. Participants would state:

Participant 1: "... it's not that painful for me to want to do anything about it"

Participant 3: "... on the scale of injuries I've had this is quite minor ... it's not that painful"

Participant 5: "... it's not that painful for me at the moment ... I don't feel like I need anything"

All four female participants mentioned this as a reason for not taking analgesics at this time. This led me ask participants the question as to whether or not they ever took any analgesics and responses to this question seemed to fall into two themes. Some people took pain relief for headaches, migraines and sore throats whereas others stated that they only took analgesics if pain was severe:

Participant 5: [takes pain relief normally] for "... headaches, period pain, if I'm feeling poorly with a cough, sore throat, something like that ..."

and in contrast:

Participant 2: [does not take pain relief normally] "... unless it's extremely bad which is a different case all together ... [would not take analgesics] .. not for headaches or whatever, I wouldn't ... I just don't"

Theme Two: "I'd rather know what's going on"

A second theme I drew from the data was a need to remain in control. This was mentioned by a couple of participants.

Participant 7: "... if you have pain relief ... which I have done in the past ... you can't tell if they're stuffing it up or not ... at least

then you know what's going on ... and then they're more careful as well ..."

and in another part of the interview:

Participant 7: "... I'd rather be in more of a controlled state ... and actually know what's going on than not ..."

Participant 3: [In relation to not wanting to use morphine] "... it's horrible ... I just lost my mind ..."

Though Participant 7 was not explicitly clear about what form of analgesics he was referring to I am reasonably sure it was not any OTC analgesic. His initial comment was referring to the use of dental analgesics but his later comment was in relation to expectations of ED care.

Theme Three: "Pain as a reference point"

I included this as a theme because even though only two participants talked about it they actually talked about it in some depth. Participant 2 stated that he used pain as a reference point:

Participant 2: "I like knowing how bad the pain is ... without having to cover it ... just for my own ... I see pain as a reference as to how bad something is ... I prefer to keep it as a warning sign rather than ... unless it's extremely bad which is a different case altogether"

Participant 7: "You're better to know the pain's there than not to know it's there and actually that's the problem with too much pain relief ... you can't actually feel there's a problem ... and you don't actually know there's something wrong ..."

This need to know that pain is there is different to the preceding themes of "Wanting to know what's going on" and "It's not that painful". There is an underlying need to know when pain has improved.

Theme Four: “Go to your happy place”

There were several references to trying to cope with the pain and that pain at minimal levels was tolerable. However, mention was made by participants about mechanisms for dealing with pain.

Participant 3 [*in reference to dental pain*]: “I’d rather just deal with the pain ... because of ... it’s a conditioning thing ... if I’ve been in pain it’s better to just deal with it ... and not have to go around with a numb mouth ... and know how to go to your happy place to deal with the pain ... it’s just a mechanism that you either have or don’t have ... but you can learn”

Participant 5: [*dealing with pain*] “... mind over matter as well ... focus enough ... being in the ‘right space’ ... it does help”

Participant 6: “I try to get over it ... I know it sounds stupid but ... I wouldn’t say I’m used to pain ... but I would”

This ties in with issues of tolerance and pain thresholds. Participants spoke of previous injuries helping them deal with present pain and of abilities to tolerate pain to a certain level:

Participant 3: “I seem to have a reasonably good pain threshold through practice [*referring to previous injuries*]

Participant 1: “If it’s hurting me I’ll take something for it ... beyond a certain threshold of pain I suppose”

As mentioned earlier the majority of participants did not feel as though their pain was bad enough to warrant analgesics and only three said that they did not want to take drugs at all. Participant 7 also stated that he had built up a tolerance to paracetamol:

“I had lots of accidents and emergencies so actually I took ... and was given a lot of Panadol quite consistently ... because

of that I needed more Panadol than I actually should have for my age ... and so I built up a kind of tolerance for Panadol and other pain relief ... so I try not taking any if possible so that when I actually need it, it actually kicks in"

Participant 3 also talked about a history of regular use of analgesics but did not talk about tolerance to medications. He did make reference to needing large doses of ibuprofen "just to kind of get up and going" but that now he would only take medications if really needed.

Theme Five: Aversion to taking medications

All participants stated that they either take analgesics routinely for minor aches and pains or if they did not take it routinely, they would take pain relief for extreme pain. Some participants, however, did state a generalised dislike for taking medications.

Participant 2: [Does not take analgesics] "Not for headaches or whatever, I wouldn't ... I just don't".

Participant 5: "I'd rather not have to take any medication ... I'd rather not put tablets in me or medicines in me ... if I don't have to have it I won't"

Participant 6: "My family, we try to avoid pain relief ... medication in general".

Reasons for this appeared to relate to the effects that medications might have on the body:

Participant 3: "... whatever you put in there becomes a consequence for your body ... make sure that you really need it"

Participant 5: "I'd rather keep things as natural as possible ... if I don't have to put drugs in me there's no point"

The following comment by Participant 7 also highlighted another theme in the data. This theme was the difference between prescribed medication and non-prescribed medicines.

Participant 7: "I'll take other medications like antibiotics but ... when it comes to pain relief I only take it if needs be ... if they say it's good to take local anaesthetic for whatever reason then that's good but if it's just popping Panadol ... I don't see much point if I can bear it in the meantime".

Participant 5: [Will not take medications] "... not unless it's prescribed. I don't really go down that route ... if I don't have to take medications I won't"

Participant 3 would not take pain relief because he had such a minor injury but was expecting a doctor to administer a local anaesthetic prior to suturing a laceration to his knee. What was interesting in his responses were references to ibuprofen, a non-steroidal anti-inflammatory drug, a commonly used analgesic. He seemed to view this in a separate category to other analgesics:

Participant 3: "I'd be quite happy to have some ibuprofen if I had a fall mountain biking and I'm a bit stiff ... just to warm things up a bit ... it will get me going".

The general theme throughout these participants was a sense that people did not like taking any medications unless they were told to by a doctor. Some people did talk about other ways of dealing with their health problems.

Theme Six: Complementary and alternative interventions

This was a theme that also wove its way through much of the data. "... know how to go to your happy place to deal with the pain" and "mind over matter" implied alternative ways of coping with pain. Only two participants actually mentioned any sort of complementary therapies.

Participant 5: "I'd rather keep things as natural as possible ... there are more natural forms of relief". [She mentioned lavender and tea tree oil as alternatives]

Participant 6: [talking about headaches] " ... if it's just a little I just try to sleep it off ... or do something else about it ... like get a massage ... and other things ... like take a bath to relax yourself maybe, or ... sleep"

The use of complementary and alternative medicines and interventions is quite widespread throughout the literature. Many patients presenting to ED's do try other ways of coping with pain. This will be discussed in the next chapter.

"What are your expectations of emergency care?"

The first part of my inquiry looked at why people do not take analgesics. The reasons for this varied and will be discussed in further detail in the next chapter. The second part of this research project was looking at what people expected from emergency care. Three main themes emerged from the data.

Theme Seven: "Need to know what is wrong"

The overall sense from the responses people gave was a need to know what was causing the pain. Diagnosis of either a fracture or a sprain was wanted for musculoskeletal injuries:

Participant 4: "[I] want to see what actually happened to it ... whether I've shattered it ... or fractured it ... I don't think I've broken a bone I don't think"

Participant 5: "Just to see what's happening there ..."

This raises interesting issues as to what public perceptions of a broken bone actually are. Anecdotally many people state that their bones are fractured but not actually broken whereas in reality they are both the same thing. Participant 3 presented with a laceration knee knowing that he would required suturing of his laceration.

Theme Eight: Diagnostics tests

Responses to the question of “What are your expectations of the Emergency Department?” were quite similar. Most of the people that presented with musculoskeletal injuries expected an x-ray while in the ED.

Participant 1: “I think they’ll probably examine it ... decide to x-ray it.”

Participant 2 did not think his wrist was broken however stated he was:

“... expecting probably an x-ray ...”

Participant 5: “... just a picture”

Participant 6: “I don’t know if my foot needs to X-rayed but maybe ...”

These responses indicated that participants had some preconceptions of their presenting injury as well as some understanding of medical interventions required. Two participants did not have musculoskeletal injuries and expected active interventions.

Theme Nine: Active treatment

Some participants knew exactly what was wrong with them and what sort of treatment they would receive. Participant 7 presented with a facial abscess and implied he was aware of required interventions and that they may in fact increase his experience of pain for a short time. When asked what his expectations from ED were he replied:

“Just do what they can ... I can understand if they’re doing something it might hurt a bit more ... but so long as it’s dealt with ...”

Participant 3 expected sutures for his knee laceration as well as a local anaesthetic:

“I’ll need some lignocaine when they sew it up ...”

Those participants expecting diagnostic tests also expected some form of active treatment or intervention:

Participant 2: "... I imagine they'll just bandage it and tell me to take it easy for three or four days"

Participant 6: [Expected that] "they look at my foot ... so I can put some weight on it again"

Participant's expectations of emergency care were threefold. The main theme was a need to understand their pain, or find a cause for their pain. Diagnostic tests and active treatment were also expected.

Theme Ten: Dental pain

One theme that emerged from the data was not related to either of the questions. When talking about pain, analgesics and expectations of care the majority of participants made some reference to the dentist or dental pain.

Participant 3: "So like ... going to the dentist ... I'd rather just deal with pain"

Participant 4: "I usually take Panadol except when I go to the dentist ... there's another one ... it needs to be a bit stronger"

Participant 5: [I] "had a Granddad that wouldn't even take pain relief even when going to the dentist"

Participant 7: "I take pain relief for ... stitches or getting stuff surgically done ... but not for things like ... the dentist"

They each referred to it in different ways however I thought this was quite significant. Dental pain seemed to be some sort of benchmark with which to measure pain.

Chapter summary

Some of the themes I identified were spoken about by one or two participants whereas others were spoken about more generally. Many more themes emerged from the data relating to attitudes to analgesics than expectations of emergency care. Some of these themes are similar to what previous research has shown and some of the themes were novel. A discussion of these findings follows in the next chapter.

Chapter Six

Discussion

The aim of this exploratory study was to discover why some patient's presenting to ED's do not want to take analgesics and to determine their expectations of emergency care. By understanding people's attitudes towards analgesics and their expectations of emergency care, health professionals can shape patients care and discharge education/information. This chapter will discuss the findings as detailed in Chapter Five. Each of the themes will be explored and the relevance of the findings to the clinical setting will be considered.

"Why haven't you taken any pain relief?"

This question has been asked before in a variety of studies from all over the world. From the literature search I conducted I expected to find a couple of themes. One of these was that people would state that the pain was not severe and that they could cope with the pain. I also thought that people would claim that OTC analgesics were not effective. Some of these themes did emerge from the data as did others that I was not expecting to find.

Theme One: "It's not that painful"

The majority of participants mentioned that their injury or presenting complaint was not severe enough to warrant taking analgesics. This is similar to what has been found in previous research. Nicol and Ashton-Cleary (2003) found that eleven percent of their participants gave this as a reason whereas Singer et al. (2008) found more significant results with forty-seven percent of their sample population describing their pain as tolerable.

Todd et al. (2007) conducted a study that looked at triage pain scores and correlated these with patients' desire for analgesics. They assessed patients' pain, using the zero to ten numeric pain rating scale, on presentation to an ED and found that the higher a patient rated their pain level the more likely they were to request analgesics. This seems quite an obvious finding however, not all patients that had high pain scores wanted analgesics.

Three participants in this project stated they had pain scores between four and six which, according to Smeltzer and Bare (2000) is defined as moderate pain on the pain scale. Of these, one stated that the pain was tolerable: Participant 1: "It's bearable – so I won't take anything for it", while the other two participants indicated that they used analgesics but only in extreme or severe pain.

Though the participants in the present study had not taken, and had declined to take analgesics for their presenting problem, in my data analysis I found that some of these participants took pain relief for minor complaints such as headaches and period pain. Turunen et al. (2004) conducted a population survey and found that eighty percent of people had experienced some form of pain in the previous week and that half of these had self-treated their pain with OTC analgesics. Participants complained most about neck and shoulder pain, hip pain and headache and back pain.

From my analysis, I wondered if people take analgesics for pain that they recognise, such as headaches and back pain. People have established behaviours for common ailments and will take analgesics readily to relieve this pain. This may be because they understand the cause of their pain, or the consequences of not taking analgesics, such as increasing pain or loss of function. However, when presented with a new, unknown type or cause of pain, such as a sore ankle, wrist or abdomen, they have no pre-established behaviour patterns. They do not think to use analgesics or are unsure about the consequences of using them, and therefore choose not to use them.

Turunen et al. (2005) found that daily use of analgesics increased in frequency with age. In light of my comments above, this could be due to learned behaviour and that the older one gets the more pain one has experienced and the more comfortable one is with the use and consequences of analgesic use.

Theme Two: "I'd rather know what's going on"

The need to remain in control was only mentioned by two participants but it was quite a significant reason for both of them. Loss of control is generally associated with stronger, opioid analgesics (Fins, 1997). Opiates, such as morphine have sedative effects and are only used in ED's for severe pain.

Participant 3 talks quite extensively about his negative experiences with morphine and describes the “massive emotional kind of roller coaster coming off it ... morphine – it’s horrible”.

Much of the literature cites the need to remain in control as a reason for patients not taking analgesics. Singer et al. (2008) found that patients expressed concerns at receiving analgesics in ED as they wanted to remain alert and analgesics would make them “groggy” (p. 3). Beel et al. (2000) found that seventy percent of patients presenting to an ED with fractures wanted pain control without sedation and only twenty-five percent were not concerned about sedation.

There is a need for health professionals to explain to patients about the side effects of analgesics when discussing the need for pain relief. By explaining to patients that they can have pain relief but still remain alert and orientated can lead to patients having improved health care experiences and better health outcomes.

Theme Three: “Pain as a reference point’

Participant 2 talked about pain as a reference point: “I see pain as a reference as to how bad something is ...” and Participant 7 stated that the problem with taking analgesics was that “you can’t actually feel there’s a problem”. I first heard this comment from a friend several years ago. He had backache and I asked him why he had not taken any pain relief. His response to me was “Well ... how will I know when it’s better?” I had no idea how to respond to this but was surprised when this emerged as a theme from my data.

Monsivais and McNeill (2007) write that many people stop taking medications periodically to determine if there is any improvement in an illness and to determine if they should continue taking a medication. However, a literature search into pain as a reference point failed to come up with any findings. Health professionals need to remain aware that this is a potential reason for patients not taking analgesics and factor it into their health care plan.

Theme Four: “Go to your happy place”

The idea that there are ways that the mind can influence health and illness is not new and can be traced back to Socrates and Hippocrates (Brannon & Feist, 2007). In more recent times there has been a division between the mind and body. This gave rise to the biomedical model of care where the physical side of illness was the main focus for health professionals. In the past twenty to thirty years however, there has been a realisation that behavioural, social and psychological factors are important to people’s responses to health and illness (Lyons & Chamberlain, 2006). This has given rise to new fields of research and practice.

Three participants mentioned psychological mechanisms to deal with pain. Participant Five said that there was an element of “mind over matter” in helping her deal with pain. This is similar to what has been found in previous studies. Bostrom (1997) writes that respondents believe in “mind over matter when dealing with pain” (p. 168) and that thinking about pain can make it seem worse.

According to Adams and Field (2001) previous experiences also have a marked impression on how patients deal with pain. This includes not just previous experience with pain, illness and clinical settings but also role models that patients may have had that have shaped responses to pain. Participant Six spoke about how neither she nor her family took medications routinely.

Theme Five: Aversion to taking medications

Patients have many concerns about taking medications. These concerns range from a fear of becoming addicted to medications; concerns about potential side effects of medications; and a fear that with prolonged or repeated use a medication will become ineffective (Bostrom, 1997; Nicol & Ashton-Cleary, 2003; Thomas, 2007). These were some of the concerns that were indicated by the participants in the current study. Three of the seven participants mentioned an aversion to taking medications: Participant 5: “I’d rather not put tablets in me” and Participant 6: “My family, we try to avoid pain relief ... medication in general”. Reasons given were a desire to keep things as natural as possible and an awareness that taking medications may have side effects: Participant 3: “...whatever you put in there becomes a consequence for your body”.

Monsivais and McNeill (2007) found that there is a belief that using analgesics will lead to developing a tolerance to them, that is that they will become ineffective when really needed. Their focus was on patients with chronic pain but Dawson et al. (2005), looked at patients experiencing cancer related and non-cancer related pain. They found that patients taking analgesics had a fear of addiction; a fear that analgesics could mask symptoms and concerns about developing a tolerance to their medications. Participant 7 raised concerns about this tolerance and talked about using analgesics “strategically”, trying not to use analgesics if possible so that when he did need them, for some future injury, they would be effective.

The other theme that arose from participant responses was a reluctance to self-administer pain relief but an acceptance of medications if prescribed by a doctor. This has been documented in previous research. Corbally and Gallagher (2006) cite research that shows that many patients believe that OTC’s are not real medications. These patients attend ED’s for stronger analgesics. Though none of the participants in this present study actually stated that OTC’s were not effective, this was something I was expecting to find. What participants did state was that they did not like taking medications unless they were prescribed. Non-pharmacological means of dealing with pain were also mentioned by participants.

Theme Six: Complementary and alternative interventions

Participants in the current study talked about different ways of coping with pain. Participant Five spoke of keeping things as natural as possible and Participant 6 talked about sleep and massage as means of coping with pain. I chose to call this theme complementary and alternative interventions rather than limiting it to complementary and alternative medicines. Medicine is defined as the practice of diagnosing, treating or preventing disease or illness and any drug or preparation used for the treatment or prevention of disease or illness (Harris, Nagy & Vardaxis, 2006). Although orthodox medicine is dominant in Western society it is not in isolation to complementary or alternative therapies. There are many ways of dealing with pain other than medicines and there is a large body

of evidence to show that many people use complementary or alternative interventions to deal with their pain.

Shi et al. (2007) found that almost all patients that experience pain and seek medical help, had tried other means of trying to deal with their pain. These methods included OTC medications, home remedies, bed rest and prayer. Bostrom (1997) found that over three-quarters of her respondents would rather try natural pain relief techniques, such as relaxation, massage and exercise, before resorting to pharmacological interventions. Bassols, Bosch and Banos (2002) found that many people treat their minor ailments with non-pharmacological therapies. Turunen et al. (2004) conducted a population survey and found that fifty-two percent of people used exercise as a means to cope with pain. Their results however, showed that natural and herbal products were only used by 0.8 percent of the population. All these studies were conducted in different parts of the world and cultural differences could account for the variation in results.

Stevenson, Britten, Barry, Bradley and Barber (2003) write that most people treat themselves with three overlapping methods, "the popular, the professional and the folk sectors" (p.513). Included in the popular sector are things such as exercise, healthy diet and home remedies (those beliefs and behaviours handed down through the generations).

The professional sector is made up of health care professionals and is known amongst other things as the biomedical model of care or orthodox care. Stevenson et al. (2003) describe folk medicine as CAM and include health food shops, and herbal remedies. Overlap in care, between orthodox and CAM interventions is increasing, therefore the professional sector needs to ensure that questions are asked about popular and folk remedies. However, patients are often not comfortable about discussing self treatment and similarly health professionals often do not like asking.

Within the NZ context, Nicholson (2006) found that a third of patients presenting to an emergency department used some form of CAM, including rescue remedy, garlic and traditional Maori medications, such as dock leaves and

manuka honey. She also suggested that all patients that present to ED should routinely be asked about the use of alternative therapies. This is similar to what was recommended by Rolniak et al. (2004) who stated that, given that nearly half of their patient population visiting ED's using CAM, all patients should be questioned routinely about their use of alternative interventions. Reasons given for this need to increase awareness, is the potential for adverse interactions between some CAM and orthodox medicine.

Summary of themes linked to analgesics

There are many reasons that patients do not take OTC analgesics prior to attending ED's and just as many reasons that people do not take analgesics when offered them at triage. There is a fear of developing tolerance to medications, and a fear of adverse side effects of analgesics. The main reason given by patients for not wanting to take analgesics was that the pain was tolerable.

“What are your expectations of emergency care?”

The second part of this project looked at expectations that participants had of emergency services. Three main themes emerged and these were a need to know what the underlying cause for the pain was, a perceived need for diagnostic tests and a need for some form of active treatment.

Theme Seven: “Need to know what’s wrong”

This theme, of needing to find out what was the cause of pain, was voiced by nearly all participants. This is similar to what other research has found. Glenton (2003) studied the ‘sick role’ concept and looked at people with chronic back pain. Issues arise with people that suffer chronic pain without diagnosis because they feel no one believes their suffering and there is “a fear that the reality of one’s pain is being questioned” (Glenton, 2003, p. 2243). She found there was a need to legitimise illness/pain and through a diagnosis, issues of malingering and hypochondria would be dispelled. I believe that by finding a meaning for their pain even people with acute injuries feel legitimised. A diagnosis also confirms that the person acted in an appropriate manner by accessing emergency services.

Fins (1997), commenting on the results of the Mayday Fund Survey, writes that up to eighty-eight percent of respondents thought that it was more important to treat the cause of pain rather than the pain itself. Ten years later similar results were found by Singer et al. (2008) with patients focusing on identifying and treating the cause of pain rather than pain itself. Allcock et al. (2007) also found that patients had a need to find a cause for their pain. They found that many patients thought that prescribing analgesics was not enough, that by treating the symptoms rather than finding the cause of pain, health professionals were “fobbing off” patients (Allcock et al, 2007, p. 249). One of the ways of finding the underlying cause of pain is through diagnostic tests.

Theme Eight: Diagnostic tests

Coupled with the need to know what is wrong is the belief that diagnostic tests, particularly an x-ray, are needed to confirm a diagnosis. Moll van Charante et al. (2008) found a similar result with thirty-six percent of participants presenting to an ED stating that they had an expectation of some sort of diagnostic investigation. This study compared reasons why patients attended the ED rather than primary health providers (such as GP services) and found that patients thought that access to diagnostic facilities was easier through ED's than GP's.

Fish Ragin et al. (2005) found that participants in their study preferred to access ED services rather than GP services because of the “comprehensive range of services available in a single location” (p. 1163). These services included radiology and laboratory tests and access to specialist consultations.

Patients access health services with specific agendas. They have already interpreted their symptoms and made the assessment that they require some sort of medical intervention. Drew (2001) writes that patients offer information to health professionals that reinforce their lay diagnoses. Patients also have thoughts as to how their treatment and recovery should progress (Lalljee, Lamb & Carnibella, 1993).

Patients seek medical care with preconceptions in mind. This was evident in this research project in that all participants expected an x-ray or some form of

active treatment. Five of the seven participants mentioned the need for some form of diagnostic test – in particular an x-ray. This implies some interpretation from participants as to cause of pain, as well as an understanding of processes and procedures in ED.

However, not all musculoskeletal injuries require x-rays. All foot and ankle injuries should be assessed according to a standardised assessment tool called the Ottawa ankle rules. These are a set of guidelines used by health professionals to help them decide if a foot or ankle injury should be x-rayed (Bachmann, Kolb, Koller, Steurer & ter Riet, 2003). Other injuries may not require x-rays because treatment of the injury would be the same for a fracture or for a sprain and it is deemed better to not expose patients to unnecessary radiation. Patients that are expecting an x-ray as part of their health experience may be dissatisfied with health care services if it does not happen.

Theme Nine: Active treatment

Another theme that emerged from the data was an expectation of active treatment. This was the same whether the participant thought they had a fracture or not. Participant 1 spoke of the results of her expected x-ray leading to a plaster of Paris (POP) cast, if a fracture was diagnosed or, a bandage if it was just a “nasty sprain”.

Jackson et al. (2005) found that becoming aware of meanings behind pain may have implications for improving coping and increasing function. Participant 6 presented with an injured foot and on presentation stated she was unable to mobilise because of the pain. She stated that she wanted someone to look at her foot:

“... so I can put some weight on it again ... it would be excellent to be able to walk ... I don't know if my foot needs to be x-rayed but maybe ... it's like it's my foot and not my ankle ... so I don't really know what's wrong with it ...”

She walked out of the department after an x-ray and no analgesics. By knowing the underlying cause for the pain it became more tolerable and she was able to weight bear again. Fins (1997) writes of this phenomenon referring to how pain

often disappears while sitting in the waiting room of a health professional. He states that once a patient “understands when the pain might be attended to and, more importantly, what the pain represents, there will be relief, at one level, even before the physical source is treated” (Fins, 1997, p. 169).

Similarly, White (2007) found one of the most important interventions that health professionals could initiate was reassurance. After patients “had the nature of their injuries explained to them and they knew these were not serious, their perspectives on their pain was changed” (p. 27). In this way, the patient that could not walk on an injured limb on arrival to ED is able to leave the department without pharmacological intervention.

Theme Ten: Dental pain

Four of the participants mentioned going to the dentist. Though three of the four participants mentioned not taking analgesics for the dentist, and one mentioned having to take something stronger than paracetamol, I found it interesting that they each used it as a reference point. Though there are many measures of dental pain and dental anxiety (Newton & Buck, 2000), I have not been able to find any literature that looks at dental pain being used as a reference point for other pain. This could be that one knows that the pain one experiences when going to the dentist is short-lived and with purpose and I think this is something that is worth further inquiry.

Summary of themes linked to expectations of emergency care

Bostrom (1997) writes that previous experiences with health professionals and clinical settings may influence/develop perceptions and responses to pain. Some participants in the present study knew exactly what was wrong with them, and knew exactly what to expect from the ED. For example Participant 3 knew he had a laceration to his knee, and knew that it needed a local anaesthetic and suturing. It is those patients that have an unknown cause for their pain, for example a painful wrist following a fall, that expect diagnostic tests leading to a diagnosis.

Limitations

Several limitations should be considered when looking at the results of this study. These include the sample size and role conflict between researcher and RN.

Sample Size

Initially, when I first chose to investigate the topic, in March 2007, it appeared as though a significant number of patients presenting to the ED had not taken analgesics and did not want them. In talking with nursing and medical staff from the department I also received feedback that it was an issue for many of them and that significant numbers of patients presenting, fulfilled the selection criteria.

I spent approximately fifty hours waiting to recruit participants in November and December of 2008 and part of January, 2009 and in that time frame seven patients fulfilled the selection criteria. All other patients that presented to the triage desk with a minor illness or injury, had taken analgesics prior to arriving in ED or accepted them when offered by the triage nurse. One then needs to ask why there no longer seemed to be an issue? For this to be explicitly clear one would really need to have numbers of people presenting to the department in pain, and look at the ratio of people that did and did not take analgesics. Though I could gather this data retrospectively, by looking at records for the days and times I was actively recruiting participants in the ED, this would require added approval from the Ethics Committee and unfortunately, was not within the scope of this project.

Research into how many people present to emergency departments in pain from other countries shows that there is a wide variation between results. Some data shows that fifty-six percent of the population take analgesics prior to attending ED's (Heard et al., 2006) with others finding that less than twenty percent take analgesics (Corbally & Gallagher, 2006). One would really need to do a meta-analysis to make any conclusions as to why this is. Again, this was not within the scope of this project.

One possible reason for the number of participants recruited in the current project may be due to recent media publicity about over-crowding in ED's throughout NZ and long waiting times to see medical staff. Reports of Wellington's ED overcrowding and long waiting times have been highlighted in the media for several months (Newstalkzb, 2008; Palmer, 2008). This heavy media coverage of overcrowding may have had some impact on the amount of presentations to the department. Alternatively, patients could be more aware of the long waiting times to see a doctor and therefore more willing to take analgesics to make the wait more comfortable.

The sample size consisted of seven participants. In qualitative work large numbers of participants are not required and one can do an in depth analysis of just one participant. However, the method of semi structured interview selected for this project called for active recruitment until saturation of data occurred. Some of Participant 7's comments corresponded with previous participant's responses however, he was still adding new information to the existing data. I would have liked to recruit more participants, so that trends and themes could be more clearly defined and confirmed, but this was not possible within the scope of this thesis project.

Due to the population size, no correlation was made between age, gender or ethnicity and attitudes to analgesics and expectations of care. It would have been useful to determine if pain scores had any correlation with expectations of care.

It is interesting to note that over the two and a half month participant recruitment period, ED doctors and nurses continued to state that patients declining analgesics was an issue worthy of investigation. Almost all staff I spoke with could give examples of patients that they cared for recently that had declined analgesics. This may warrant further study. To clarify this issue information will have to be gathered as to the number of people presenting to the triage desk in pain that accepted analgesics or had taken something before arriving in the ED. By comparing these figures to the numbers that decline analgesics one may be able to draw some conclusions as to whether there is an issue or not.

Singer et al. (2008) found that almost half of the people presenting to ED's did not want analgesics. Todd et al. (2007) found that pain was the most common reason for people to access emergency services and that up to seventy percent of patients did request analgesics. I do not believe that either of these statistics is reflective of the patients that visit Wellington ED. This warrants further study.

Role conflict

Difficulties did arise when ED was busy and short staffed and I was present to conduct interviews. Staff would ask me to help with small tasks and it was difficult to say no to these requests when I was just sitting and waiting for patients to arrive that fulfilled selection criteria. This process became easier as staff became more familiar with me coming in to conduct interviews.

It was also difficult to maintain my role as a researcher when participants would ask questions about pain relief. For example in Interview 3 the participant asked about whether she could take paracetamol and ibuprofen together. This question was asked in the middle of the interview and made me feel quite uncomfortable. As a RN, I knew the answer to this question, however, as a researcher I was unsure of how to respond. Fontana and Frey (2000) recommended that researchers feign ignorance when questioned by participants but, as described in Chapter Four, I could not do this. I stopped the interview and sought help from the triage nurse.

Another issue I have identified is that even though I presented myself to participants as a Masters student, when listening to the audio tapes I heard myself talking about the ED at times and saying "What we do in ED is ..." I wonder whether by inadvertently aligning myself to the health service I received different responses to that which I would have had I remained completely 'neutral'. I am sure that if I had conducted the research as a registered nurse, responses would have been different again.

How to present oneself

Fontana and Frey (2000) discuss the dilemma of how an interviewer should present themselves to interviewees. They write that the decision of whether to present oneself as a professional or whether to "dress down" to look like the respondents can have a major impact on the course of an interview. Baker

(cited in Fontana & Frey, 2000) writes "... a researcher telling a respondent "I'm a mother of three" versus telling her "I am a university professor" accesses different categories and elicits different accounts" (p. 666). In my initial interviews I dressed professionally – very neat and tidy and introduced myself as a Masters student. In subsequent interviews I modified my dress code and wore jeans and a t-shirt. I felt that the later interviews were more relaxed and that patients responded better to my questions. This could of course have been because I relaxed a bit more after the initial couple of interviews.

I also wonder how responses would have differed if I had presented myself as a registered nurse. According to popular media polls RN's are among the most respected and trusted professions (Readers Digest, 2008). I believe that the trust between 'nurse researcher' and participant may have been easier to establish than between 'student researcher' and participant. However, the responses given by participants may well have differed if talking to a health professional rather than a 'lay' person.

Demographics

As mentioned in the previous chapter this information was gathered to lend support to the qualitative aspects of the data and for descriptive purposes. With seven participants' I have not attempted to highlight any similarities or differences between male and female participants, across ages or ethnicities. Use of the pain scale is also limited due to limited sample size. The demographic data can only be used for descriptive purposes.

The issue of trustworthiness can be questioned in qualitative work. Trustworthiness can be established in qualitative work by the way researchers inform readers of the thought processes and decision making involved throughout their research projects. Chenail (1995) writes that researchers need to communicate clearly in their written work about choices and decisions made throughout their research projects. This includes thoughts that occurred but were not followed through, and reasons for taking certain pathways and not others. This is what I have attempted to do in this piece of work.

Chapter summary

I have discussed the main themes I identified from the data. Many of the findings are similar to those found in overseas studies however, there were some surprises. As mentioned earlier I expected to find that people would decline OTC's such as paracetamol or ibuprofen but want something stronger – yet no one did this. I expected responses to include the fear of 'masking symptoms' so that the doctors would not find anything wrong, but this was not given as a rationale for patient behaviour.

I also expected that more women would have mentioned childbirth as a reference point for pain. Only one participant mentioned this however, I am not sure whether any of the other female participants had experienced childbirth. As discussed earlier, childbirth is often used as a reference point for women in pain (Bendelow, 2006).

Patients often wait after injuring themselves, to see if their pain improves before accessing health care services (Cameron et al., 1995). This is something else I was expecting to find however, most of the participants presented soon after injury. Only one participant deferred accessing ED services and this was due to her awareness that the department was often busy on a Saturday night and that a Sunday morning might be quieter.

Participant 6: "I did this last night, just before I went to bed and so I went to bed hoping it would go away ... and [I knew] it was a Saturday night and the department is quite busy ... I've been here before ... had to wait 5 hours waiting with a friend who had cut her finger ... I was hoping I wouldn't have to wait that long ..."

The aim of this study was to explore the reasons why patients had not taken analgesics and what they expected from emergency care. General themes have been identified. Two out of the three males stated reasons for not taking analgesics was a need to remain in control. All of the female participants stated that the pain was not bad enough to warrant taking analgesics. Whether these are trends or isolated findings was not possible to determine.

Chapter Seven

Conclusion

I have spent many hours as a registered nurse sitting at a triage desk assessing and observing patients. The 'patient' that I could never understand was the one that would arrive in obvious pain (limping, holding their wrist or abdomen), not having taken any analgesics prior to presentation. When offered paracetamol and/or ibuprofen by a RN at the triage desk, these patients would decline analgesics. My thinking was "If the pain is bad enough to require presentation at an Emergency Department surely it must be bad enough to warrant analgesics". Given that one of the major roles of nurses in ED is the administration of prescribed analgesics, I would wonder what these patients expected from the ED. This led to the development of this current research project.

Patients present to ED's without taking analgesics and decline them when offered by health professionals for many reasons. Seven participants were recruited for this project, each provided rationales for their behaviour and several themes have emerged from their data. Reasons included the sense of needing to remain in control, the use of alternative methods of coping with pain and, the most common theme, the pain was at a tolerable level. Of most surprise to me was that dental pain was mentioned as a reference point by the majority of participants. As previous research has shown people have rationales for their behaviours and health professionals need to be acutely aware of this.

Fins (1997) writes that patients in pain "seek to understand what the pain portends for their future health and happiness" (p. 169). They need to know the potential impact on their lives and have some understanding the course of their recovery. The most common expectation for participants in this study was that emergency care services would provide an understanding of the underlying cause of the pain.

Recommendations

This work would be enhanced by doing follow-up interviews with patients and staff. I would like to know if patients who declined analgesics by the triage

nurse accepted them when offered or prescribed by their emergency doctor. This fits into those themes that emerged from participants about taking medications if prescribed. Did patients decline OTC analgesics because they were offered by a nurse?

Staff also need to be questioned to determine how their perceptions of the numbers of patients presenting to the ED without taking analgesics, and declining then when offered, correlate with actual numbers of patients who present to ED and decline analgesics. Do large numbers of patients decline analgesics or not?

The use of dental pain as a reference point for describing other pain was an unexpected theme to emerge from the data. I have been unable to find any literature that has looked at this and feel as though this also warrants further investigation.

The use of CAM should be investigated by all health professionals not just those in ED's. As Nicholson (2006) found there is a high use of CAM within NZ patients presenting to ED's and the negative interactions some of these can have with conventional medications should not be minimised. Patients do use non-pharmacological means of dealing with pain and these should be identified and respected by health professionals.

Conclusion: My reflections on the thesis process

Learning the processes involved in research is as much part of this assessment as is finding new information, or confirming findings from existing research. I believe I have generated more questions for myself and avenues for future research than I have answered my original research question.

I now realise that I approached this piece of research from a purely biomedical model. Triage nurses are taught to ask about analgesics not to ask "What have you done to make the pain better?" Heat packs, herbal remedies, complementary and alternative interventions tend to be looked at in the light of how they will interact with conventional therapies (Rolniak et al., 2004). Health professionals ask "What potential significant interactions will there be with what

we want to do?" This is of course a generalisation and I am sure that there are many practitioners who work within the health care system that have holistic, naturalistic approaches to all their interventions. I want to know whether patients would accept non-pharmacological interventions at triage. The simple first aid that the triage nurse should offer patients with musculoskeletal injuries, such as ice and support (that is a sling, a splint, elevating the injured limb) are included in these non-pharmacological interventions but I question if a CAM such as arnica, which is used to minimise bruising, was offered at the triage desk would it be accepted by patients or staff.

I have also become aware of the words that are used in this field of study and practice. Analgesics, pain relief, pain reliever, pain killers and pain pills are used interchangeably. It would be interesting to determine if the words used by people had any impact on the effectiveness of a medication. For example if a person requests a pain killer it implies that pain will be eliminated – a complete absence of pain. Analgesics have been defined above as relieving pain; they decrease pain, make pain more tolerable but do not necessarily eliminate it completely. Administration of a 'pain killer' may not work for a patient whereas administration of 'pain relief' may be more effective.

When I came to analyse the data I realised that I had not really asked the question I most wanted answered. By listening to participants telling me they wanted x-rays made me wonder if they were aware that primary health care providers also had diagnostic equipment. What I really wanted to ask was why they had accessed ED services rather than GP services. Research conducted overseas, has shown that people access emergency services not just for diagnostic reasons but for financial reasons as well (Fish Ragin et al., 2005). Given that ED's generally provide free health care services, and GP's charge for their services, it would be interesting to determine how many patients consider this cost of when determining where to seek health care. There are GP services available that provide after-hours care and there are services that provide diagnostic services.

Finally there is the need to recognise that this study has been conducted from a nursing/psychology perspective. I am not one without the other and at times I

felt as though this work was too nursing focused to be able to fit amongst the tomes of psychological research that is out there. I have endeavoured to maintain a health psychology focus. Nevertheless, I am who I am and this work is a reflection of my two fields of interest – nursing and psychology. I hope that I have added something to the field of psychology and also to that of health.

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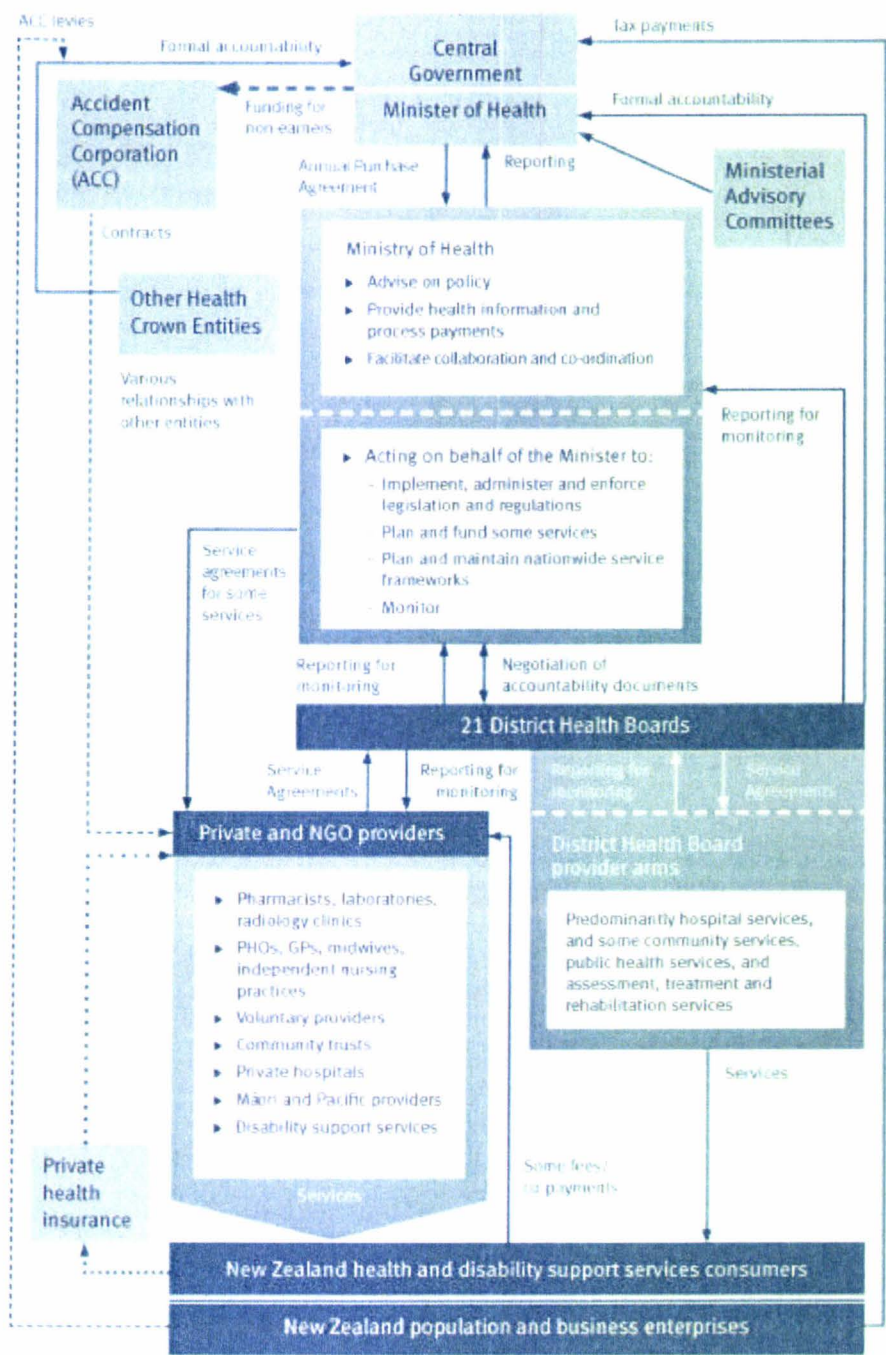
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Appendix One

The structure of the health and disability sector 2008

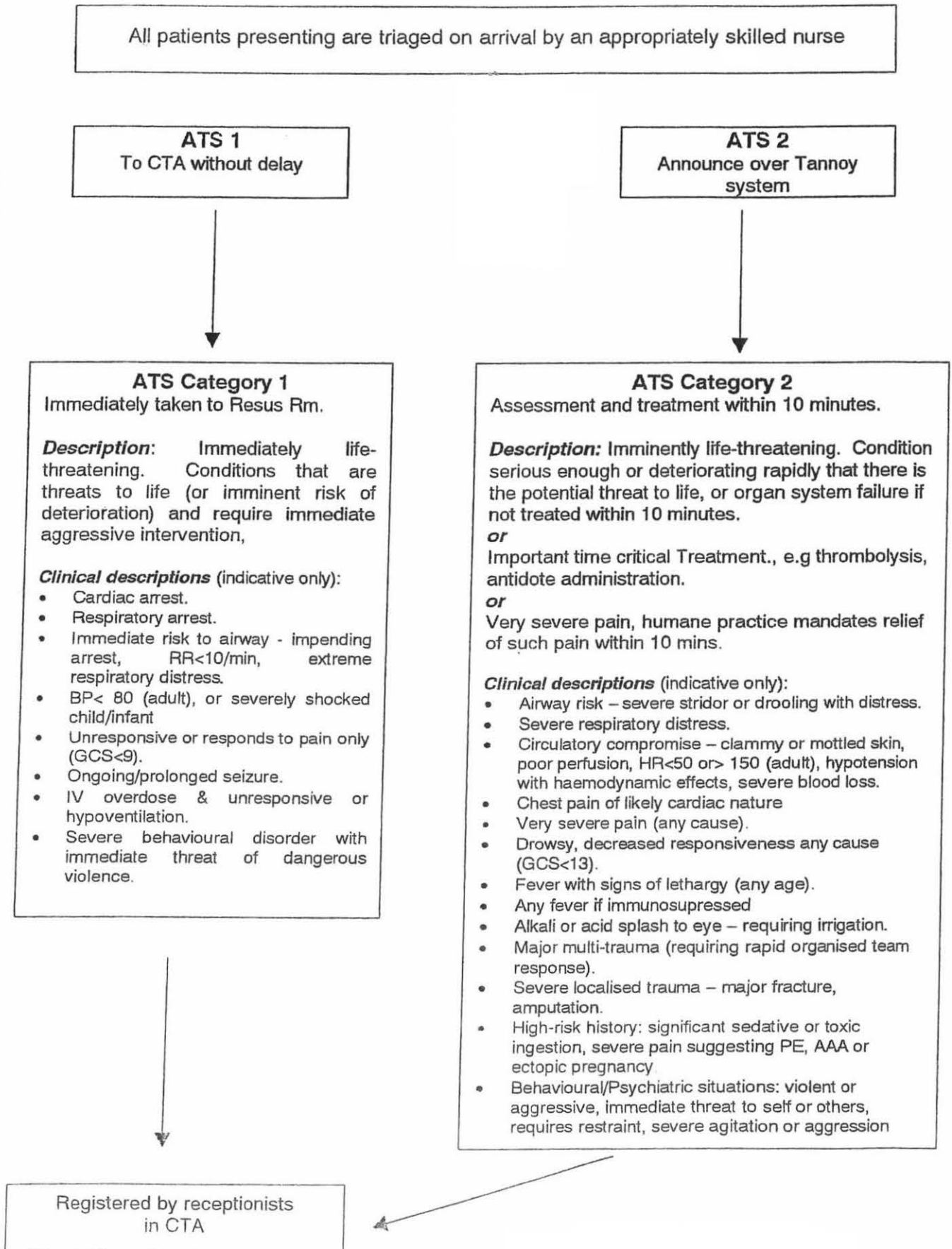
The structure of the New Zealand health and disability sector



(Ministry of Health, 2008b)

Appendix Two

Triage Clinical Pathway



(from Mitchell, 1999)

Triage Clinical Pathway

All patients presenting are triaged on arrival by an appropriately skilled nurse

ATS 3, ATS 4 and ATS 5

ATS Category 3

Assessment and treatment starts within 30 minutes.

Description: Potentially Life-Threatening

The patient's condition may progress to limb or life threatening, or may lead to significant morbidity, if not attended to within 30 mins of arrival.

or **Situational Urgency**

There is potential for adverse outcome if time-critical treatment is not commenced within 30 mins.

or
Severe pain- human practice mandates relief of such pain within 30 mins.

Clinical descriptions (indicative only)

- Severe hypertension
- Moderately severe blood loss
- Moderately SOB
- Seizure, now alert
- Persistent vomiting
- Dehydration
- Head injury with short loss of consciousness – now alert
- Moderately severe pain
- Chest pain, likely non-cardiac (moderately severe).
- Abdo pain without high risk Hx (moderately severe).
- Moderate limb injury – deformity, severe laceration, crush.
- Limb – altered sensation, acutely absent pulse
- Trauma – high-risk Hx, no other high-risk features.
- Stable neonate
- Child at risk
- Behavioural/Psychiatric, very distressed, risk of self-harm, acutely psychotic or thought disordered, situational crisis, deliberate self-harm, agitated/withdrawn, potentially aggressive

ATS Category 4

Assessment and treatment starts within 60 minutes.

Description: Potentially Serious

The patient's condition may deteriorate, or adverse outcome may result, if assessment and treatment is not commenced within 1 hour of arrival in ED.

Symptoms moderate or prolonged.

or **Situational Urgency**

There is potential for adverse outcome if time-critical treatment is not commenced within 1 hour.

or **Significant complexity or severity**

Likely to require complex work-up and consultation and/or inpatient management.

or
Discomfort or distress - human practice mandates relief of such distress within 1 hour.

Clinical descriptions (indicative only)

- Mild haemorrhage
- Foreign body aspiration, no resp. distress
- Chest injury without rib pain or respiratory distress
- Difficulty swallowing, no resp. distress.
- Minor head injury, no loss of consciousness.
- Moderate pain, some risk features
- Vomiting or diarrhoea without dehydration
- Eye inflammation or F/B, normal vision.
- Minor limb trauma – sprains, possible fracture, uncomplicated laceration.
- Non-specific abdo pain
- Swollen hot joint
- Behavioural/Psychiatric, - semi-urgent, under observation, no immediate risk to self or others.

ATS Category 5

Assessment and treatment starts within 120 minutes.

Description: Less Urgent

The patient's condition is chronic or minor enough that symptoms or clinical outcome will not be significantly affected if assessment and treatment are delayed up to 2 hours.

or **Clinico-administrative problems**

Results, review, medical certificates, prescriptions only.

Clinical descriptions (indicative only)

- Minimal pain, no risk features
- Low-risk history now asymptomatic
- Minor symptoms
- Minor wounds
- Scheduled revisit
- Immunisation only
- Behavioural/Psychiatric – known patient with chronic symptoms, social crisis, clinically well patient

Registered by receptionists
Patient waits in reception area

Appendix Three



Central Regional Ethics Committee
Ministry of Health
Level 2, 1-3 The Terrace
PO Box 5013
Wellington
Phone: (04) 496 2405
Fax: (04) 496 2191
Email: central_ethicscommittee@moh.govt.nz

29 October 2008

Ms Jolanda Lemow

Dear Ms Lemow

What are patients attitudes to analgesics; why don't they take them and what do they expect from emergency health care services.
Ms Jolanda Lemow, Dr Steve Humphries
CCDHB -CEN/08/07/037

The above study has been given ethical approval by the Chairperson of the **Central Regional Ethics Committee** under delegated authority.

Approved Documents:

- The declarations (Part 4), v 1, 2005
- Information Sheet, v 2 September 2008 – Project Title: Public attitudes to Pain Relief and expectations of emergency Care
- Question Guidelines, v 2, September 2008
- Participant Consent Form, September 2008
- Locality Assessment.

Accreditation

The Committee involved in the approval of this study is accredited by the Health Research Council and is constituted and operates in accordance with the Operational Standard for Ethics Committees, April 2006.

Final Report

The study is approved until **01/02/2009**. A final report is required at the end of the study and a form to assist with this is available at <http://www.ethicscommittees.health.govt.nz>. If the study will not be completed as advised, please forward a progress report and an application for extension of ethical approval one month before the above date.

Amendments

It is also a condition of approval that the Committee is advised of any adverse events, if the study does not commence, or the study is altered in any way, including all documentation eg advertisements, letters to prospective participants.

Please quote the above ethics committee reference number in all correspondence.

It should be noted that Ethics Committee approval does not imply any resource commitment or administrative facilitation by any healthcare provider within whose facility the research is to be carried out. Where applicable, authority for this must be obtained separately from the appropriate manager within the organisation.

Yours sincerely

Sonia Scott
Central Regional Ethics Committee Administrator



Information Sheet

Project Title: Public attitudes to pain relief and expectations of emergency care.

My name is Jolanda Lemow and I'm a Master of Arts student at Massey University. I am doing research into people's attitudes to pain relief as well as their expectations of emergency care. You may be approached by me and asked if you are willing to participate in this research project. Your participation is entirely voluntary (your choice). You can stop me at any stage if you don't want to continue. You can ask questions at any stage. You will be asked to sign a consent form.

Participant selection:

You have been selected because you have said that you do not want to take any pain relief. I will ask you a few short questions about why this is and what care you expect from the Emergency Department.

Where will the study be held?

You will be offered a choice of being interviewed in the waiting room of the Emergency Department or in a private interview room in the Emergency Department. ***There will be no impact on your waiting time or your treatment.***

Time:

Interviews will only take 10 to 15 minutes. There will be no follow up. I would like to digitally record your responses but if you do not want me to do this please let me know.

Results:

The results of this project will be reported in a thesis. Results may also be used for conference presentations or in a medical or nursing journal article in the future. Staff from the Emergency department and students nurses will also be informed of the findings of this project.

Benefits of the study:

The results of this study will inform the future practice of health care providers. This means that doctors, nurses and other health providers will gain

understanding about what people living in New Zealand think about pain relief and what they expect from doctors and nurses in the Emergency Department.

Confidentiality:

No material which could personally identify you will be used in any reports on this study. Recordings will be kept as digital audio files and will be destroyed once the research project is completed. Quotes from your responses may be used in the project but all responses will remain anonymous and confidential.

If you change your mind about participating in this research project and wish to withdraw from the study you can do so before 30th October, 2008. Please contact me on 237 3103 ext 3945 and give me your "Interview Number".

If you have any questions about this research you can contact my supervisor, Dr. Linda Jones.

If you have any questions or concerns about your rights as a participant in this research study you can contact an independent health and disability advocate. This is a free service provided under the Health and Disability Commissioner Act:

Telephone (NZ wide): 0800 555 050
Free Fax (NZ wide): 08002787 7678 (0800 2 SUPPORT)
Email (NZ wide): advocacy@hdc.org.nz

This research project has received ethical approval from the Central Regional Ethics Committee.

Thank You

Jolanda Lemow

Principle Investigator:

Jolanda Lemow
Nurse Lecturer
Nursing Centre of Learning
Whitireia Community Polytechnic
(04) 237 3103 Extension 3945

Thesis Supervisor:

Dr Linda Jones
Senior Lecturer
School of Psychology
Massey University.
(04) 801 5799 Extension 6530

Your "Interview Number" is _____



Participant Consent Form

Research Project Title: What are patient's attitudes to analgesics; why don't they take them and what do they expect from emergency health care services?

1. I have read and I understand the Information Sheet dated September, 2008 for volunteers taking part in this study and have had the details of the study explained to me.
2. My questions about the study have been answered to my satisfaction, and I understand that I may ask further questions at any time.
3. I understand that taking part in this study is voluntary (my choice). I also understand that I am free to withdraw from the study at any time, and that I can choose not to answer any particular question in the study.
4. I have had the opportunity to use whanau support or a friend to help me ask questions and understand the study.
5. I understand that my participation in this study is confidential and that no material which could identify me will be used in any reports on this study.
6. I know who to contact if I have any questions about the study.

I _____ (full name) hereby consent to take part in this study.

Signature: _____

Date: _____

Full name of Researcher: Jolanda Lemow

Contact Phone Number for researcher: (04) 237 3100 Extension 3945

Project explained by: Jolanda Lemow – Principal Researcher

Signature: _____

Date: _____

Appendix Six
H E & R Services Ltd
86 Takapuwhia Drive, Porirua
Ph: 04 2375613

[REDACTED]

4 August 2008

Jolanda Lemow
Nurse Lecturer
Nursing Centre of Learning: Undergraduate Studies
Whitireia Community Polytechnic
Wineera Drive
Porirua City

Tena koe Jolanda,

**Re: Research Proposal: Clients/patients attitudes to analgesics and
Expectations of emergency care.**

I have read through your Research Proposal and would like to support the work that you have already undertaken to ensure Maori participants would be culturally safe during your study.

You have mentioned Whanau Support for the participant. This would be very important and the whanau will provide assistance to the participant while going through the study and treatment processes. Whanau provide the Mauri life essence and the wairua aspects of healing and treatment. Whanau can provide encouragement and will be able to provide assistance with any compliance issues.

It is important that the participant and whanau understand that they can withdraw from this study at any stage without compromise to future care and treatment. You have suggested in your study that this will be so.

Confidentiality of personal information is very important. People will trust you when you give assurances that all personal information shared with you will be treated with dignity and respect.

Maori people prefer to communicate Kanohi ki te Kanohi (face to face) this provides opportunity for trust and respect to develop.

It would be important to Maori participants that they are not questioned in a public place. This would cause the whanau and the participant to be whakama (shy) about discussing any personal information with you. If the person you wish to participate in your study is not well enough to discuss their pain or hospital expectations, it would be better to wait until another time.

I wish you well with your study.

Kia ora

Colleen Wineera

Director, H E & R Services Ltd
(Maori Health Education & Recreation)

Appendix Seven

Question Guidelines

Age:
Sex/Gender:
Ethnicity:

Triage Code:
MOI:
Pain Scale:

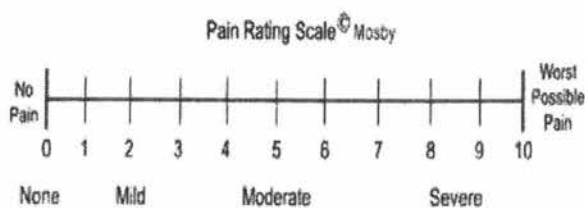
1. Can you please tell me why you haven't taken any pain relief?

2. Can you explain a little bit more about that?

3. What do you expect from your visit to the ED?

4. Is there anything else you would like to add?

5. Would you like a summary of the results of this research sent out to you?
Please write your name and/or address on this envelope and they'll be posted out to you.



Interview Number
