CHAPTER 1

INTRODUCTION TO THE STUDY
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Each day, we must actively choose to be troubled by
and attend to our patient’s pain and suffering.
Brescia, 1993, p. 51

INTRODUCTION

This chapter introduces the study. The research questions are discussed and
the format for presentation and organisation of the study is described. A
brief overview of the research framework and direction is provided.

THE RESEARCH QUESTION

The purpose of this study is two-fold: to answer the research questions and
to provide a framework that allows exploration of ‘knowing’ from an
ontological perspective. The research questions are:

- what are the ways of knowing about cancer pain from palliative care
  patients’ perspectives? and
- are ways of knowing pain important to better pain management if
  included in pain assessment strategies undertaken by nurses?

The study examined the ways of knowing pain of six people receiving
palliative care using Heideggerian phenomenology as the research
framework. Participants in the study were selected from a hospice or home-
based palliative care setting. Three ethics committees, two different hospital
committees and a university committee accepted the study. Each person in
the study agreed to participate according to the guidelines accepted by those
committees, which included ethical considerations related to confidentiality,
informed consent, anonymity, and right of refusal. Measures taken to protect these fundamental rights of participants were included in the original research proposal and subsequently accepted by the various ethics committees and are discussed in more detail in chapter four. Data collection was generated over a seven month period by in-depth interviews conducted by the researcher and by diaries kept by some of the participants. Three participants did not keep a diary either because of the degree of their illness or because they did not like writing.

Analysis of the data was conducted using a process adapted from Sandelowski (1995a, b) and van Manen (1990) with supporting guidelines from Heidegger (1926/1962) and Kaelin (1988). The process involved: data preparation and preliminary analysis suggested by Sandelowski; thematic analysis as described by van Manen; defining significant statements using criteria from Heidegger and Kaelin; and identifying themes based on the underlying philosophical framework. The research process used in this study was underpinned by Denzin’s (1989) application of Heidegger to the research process. The resulting unique and concordant process offers a means of analysis that has a basis in accepted qualitative processes and yet is tailored to the specific project and the nursing philosophy of individualised care.

THE THESIS – AN OUTLINE
The thesis presents a journey of learning and questioning about people with cancer pain who are receiving palliative care. It is located within a Heideggarian hermeneutic, and so the journey takes on a dual dimension; at one level a concern about people with cancer pain and the nurse’s role woven through that; and at another level, a philosophical inquiry that
provides not only a framework, but a vehicle by which to question and wonder at the complexity of existence. The two dimensions are not mutually exclusive and interact throughout the study.

A progressive interest about the ways people with cancer know the pain that is part of their existence grew from my experience in oncology and palliative care settings together with an ongoing reference to the literature. It evolved into a process of questioning and reflection that lead to this inquiry. In keeping with a personal philosophy about the wholeness of a human being and the unity of human existence with the world, I adopted Heidegger’s philosophy to support this inquiry. Heidegger’s analysis of the meaning of Being and oneness with the world was informed by his major work, *Sinn und Zeit*, published in Baden in 1926 and translated by Macquarie and Robertson in 1962 with the title *Being and Time*. This particular work provided the structures to underpin the practical application of a philosophical inquiry to an explication of the ways of knowing cancer pain. A Heideggarian approach also supported the notion that knowing can be situated within the meaning of being human and not just within the act of consciousness, a movement that places knowing within an ontological structure, not only an epistemological one.

The presentation of the thesis adopts a circular structure reflecting the example Heidegger set in *Being and Time*. In this work Heidegger demonstrates a circular pattern both in the presentation and the process of inquiry fundamental to the ontological structures of existence, one of which, understanding, is Heidegger’s version of the hermeneutic circle. It is within this context, that ways of knowing cancer pain were disclosed. The circularity of the study is primarily concerned with understanding and meaning in a Heideggarian sense. It begins with the interviews and
subsequent identification of structures that unfold through ontic dimensions and in their revelation turn back to the beginning and uncover the ways of knowing cancer pain within an ontological dimension. It is through this ontico-ontological process that the notion of self is restored to a place within the search for ontological meaning.

Along the way, another layer becomes evident, the role of the nurse in assessment and intervention of cancer pain. This role is linked with the patient’s knowing cancer pain, and begins with a review of the nurse’s assessment of cancer pain. The literature and the research data led to the eventual questioning of the relationship of nurse pain assessment, in relation to the intimate personal knowing of a patient with cancer pain. Following a circular path woven through the study, the analysis of the recorded texts of patients interviewed, point to the nurse’s role and finally, the application of the findings supports a role for the nurse within the context of the patient’s own knowing of their cancer pain. A new model is presented that demonstrates the conjunction between knowing pain as a means of pain assessment and the multidimensional approach to pain assessment. It then becomes obvious that the knowing pain is complementary to more traditional forms of assessment, although no less important.

As a way of demonstrating rigour within the research process application of the decision trail, or audit, based on the work of Guba and Lincoln (1989), provides for accountability for the decisions made throughout the study without the orthodoxy of quantitative verification procedures.
ORGANISATION OF THE THESIS

The organisation of the thesis will begin at the point of entering the circle, with the problems which lead to the questions asked of the study, continuing with the phenomenological methodology that supports the study. Collecting individual texts and uncovering the meaning within, the circle turns back on itself and ends where it began, confirmed by the findings from the study, with ways of knowing cancer pain.

The study is presented in seven chapters. Chapter one introduces the study, its structure, organisation and style. Chapter two reviews the literature on cancer pain to uncover the problems to be addressed by the research question. It briefly reviews the history of pain theory and how this influences attitudes and practices today. Pain assessment by nurses is discussed and problems with current assessment practices identified. Assessment is recognised as the key to appropriate pain management drawing on current literature and acknowledging the gaps that exist in the literature and in practice. A model is described from which another perspective of pain assessment can be drawn. A brief examination of the palliative care context is provided together with the relationship of pain management to palliative care philosophy and practice. Chapter three presents the methodology that grounds the study where aspects of Heideggarian philosophy relevant to the study are explained and its relevance to nursing is canvassed. Two important assumptions that underpin the study are: the accepted universality of Heidegger's concept of Being; and the seemingly contradictory notion of the place of self or the individual within the Heideggarian concept of Being. The ontological concept of knowing within a Heideggarian framework is also explored with the intention that the participant's cancer pain is examined within the Heideggarian notion of knowing. This concept of knowing is fundamental
to the identified gaps in pain assessment practices and is supported by the philosophical framework adopted.

Chapter four introduces the research method used in the study and discusses the process used to achieve rigour within the study and outlines a six point process of method used to operationalise the study. The method used to achieve rigour is based on Guba and Lincoln’s work (1989). The decision trail or audit is described and is the method I used in maintaining transparency and rigour in this study.

Chapter five identifies and discusses the common ontological themes of the participants and discusses these in respect of the Heideggerian concepts described in chapter three. Chapter six follows the notion that individual structures can be identified from common ontological ones. It discusses the findings as they relate to the individual participant and his/her relationship to the identified problems that led to the explication of ways of knowing cancer pain. Chapter seven examines meaning within an application of the study outcomes to practice, and areas identified for further consideration in nursing education and research are offered.

The first person has been used in many parts of the thesis to convey my personal involvement in the research process. Webb (1991) argues for the use of the first person in reporting qualitative research because of the social elements of the research process, the aim of the research, and in the interests of reflexivity. This study includes these three aspects of qualitative research.
Each of the participants in the study has been given a pseudonym to protect their anonymity. Any family members or other persons referred to have also been given pseudonyms.

**TERMINOLOGY**
Key terms used in the application of Heidegger’s philosophy are discussed in chapter four. Much of the terminology that Heidegger uses requires explanation because of the uniqueness of his expression, complicated by the fact that the original text has been translated from German to English.

**SUMMARY**
This study is primarily about the ways that people with cancer pain know their own pain, in terms of the totality of their existence. This is extended to explore another related aspect about the nurse’s role in pain assessment and the relationship between such assessment and the patients’ knowing their pain. Without the need for someone else to understand the pain experience, there would be no need to uncover a person’s existence with pain. Scarry (1985) argued that pain comes into our midst, unable to be shared, but at once, as something that cannot be denied and something that cannot be confirmed. She describes a situation that is relevant, although at times hidden, to any nurse who has cared for a person with pain; the dichotomy of knowing one’s own pain and knowing another person’s pain. Owning pain is to be certain and only hearing about pain is a source of doubt. Owning pain, “even with the most heroic effort it cannot not be grasped” and yet when another person owns it “even with effort one may remain in doubt about its existence; and, finally, if with the best effort of sustained attention one successfully apprehends it, the aversiveness of the ‘it’ one apprehends
will only be a shadowy fraction of the actual ‘it’” (Scarry, 1985, p. 4). This study will extend that ‘shadowy fraction’.

The following chapter will discuss contemporary aspects and concerns of cancer pain and its assessment by nurses.
CHAPTER 2

CANCER PAIN - BEGINNING THE JOURNEY
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Pain is the common companion of birth and growth, disease and death, and is a phenomenon deeply entwined with the very question of human existence. It is among the most salient of human experiences; and it precipitates questioning the meaning of life itself.

Bakan, in Quint Benoliel 1995, p. 583

INTRODUCTION

There are many ways to begin a discussion of pain; as many as there are ways of understanding pain. Degenaar (1979) cites many instances of the diversity of meanings and contexts within which pain can be explained and understood. This plurality of description stems as much from the pervasive and complex nature of pain as from the failure of the word ‘pain’ to adequately convey an individual meaning of the experience of pain. This individuality of the nature of pain, commonly referred to as the subjective nature of pain, requires an examination of the experiencing person’s understanding of their pain, as well as the nurse’s understanding of a person’s pain experience.

This chapter will address the phenomenon of pain, referring to the current body of relevant scientific and nursing literature, incorporating a philosophical perspective of the phenomenology of pain. It would seem that a philosophical perspective of pain is regarded as alternate rather than complementary to much of the current scientific thinking, demonstrated by the paucity of literature available on the phenomenology of pain. The divisions outlined below are arbitrary since they are in reality interwoven and can have an indefinable effect on pain as it exists within a person. The

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larger question - in what ways does a person know their pain, and which is embedded in the phenomenological perspective - will be answered by the research data.

UNDERSTANDING PAIN
Understanding is implicit for both the patient who has pain and the nurse who is assessing and managing the person with pain. As will be discussed in chapter three, knowing as a mode of being is integrally related to and extends understanding and interpretation of being-in-the-world (Heidegger, 1926/1962). The phenomenological method for knowing begins with understanding (Bruyn, 1996). The process of understanding should be part of any assessment, initial and ongoing, of a person with cancer pain. The process of understanding is based in the present although built on global and historical factors that influence both the person with pain who understands, and the nurse who is attempting to understand, with implications for the future of both. For Heidegger, understanding is a circular process necessary in endeavouring to penetrate the field of study, (Heidegger, 1962, p. 27), and to disclose the interpretation that already exists within the understanding of an entity (pp. 194-195).

Pain can be a very powerful experience and cancer pain even more so because it has implications for life and death. Pain is felt to be an inevitable component of cancer (Brescia, 1993) and is certainly feared because of its prevalence and its history of undertreatment. Brescia (1993, p. 49) contends that it is the indignity of the dying process and not the disease that “terrifies” patients, wishing they were dead in order to circumvent the painful dying process. This may well be so in some or even many patients, but nurses, need to know if this is true for a particular person; they need to understand
the meaning the pain has for that person. Brescia’s (1993) contention is not a universal phenomenon in patients with cancer pain, and it belies the role nurses and other health carers have in managing cancer pain. The key to personal meaning lies with interpretation and understanding, constitutive of a knowing being.

Scarry (1985) argues that there is an inherent inability to feel the pain of others, causing the pain to be an isolating experience, or in Heideggarian terms, pain places the unknowing person outside the hermeneutic circle, thus supporting Brescia’s view. As Heidegger has demonstrated, it is possible to enter the circle of another person’s understanding and for nurses this is an essential step.

Sallis (1978) asks the question of Heidegger’s work - where is the beginning of the circle of understanding? In adopting Heidegger’s philosophy of understanding it becomes important to ask where the circle of understanding pain begins. Entry to the circle must be, for the purpose of this study, within the world of pain as it is already there when a person is thrown into it, in a Heideggarian sense. A person is thrown into a culture of pain that already exists before they are able to make it a world with personal interpretation and possibilities. This circle then becomes a circle within the larger circle of the whole study, but in order to progress, it is essential to first uncover the phenomenon of cancer pain.

**PAIN - THE PHENOMENON**

This section will contribute to the understanding of the phenomenon of cancer pain by examining the literature related to: historical perspectives; current perspectives; and the nurse/patient context – the assessment of pain.
Historical and current perspectives involve the cultural and scientific influences that permeate the world of pain, although not always uniformly or in an organised way. Attitudes, expectations, treatment and ultimately individual existence, are implicated. Assessment is a means or process of uncovering the elements or dimensions of a person’s pain. It influences management of the pain and in turn is influenced by the context in which the pain occurs.

**HISTORICAL PERSPECTIVE**

The attempt to understand, explain and treat pain has been the subject of philosophy, medicine and literature for centuries and has influenced the prevailing worldview at the time. Donovan (1989) has identified a number of historical factors that have influenced attitudes, management and expectations about pain. She suggests these factors continue to influence attitudes and beliefs about pain. The following outline has been adopted from her work:

- Pain as punishment. An early reference to pain in this context occurred in the Old Testament when Adam and Eve had been ejected from the Garden of Eden, thus condemning them and the human race to suffer pain. This connection between pain, punishment and religion persisted throughout history and the existence of pain was seen as either invasion by the devil or the will of God and therefore to be endured. These views still pervade some interpretations of pain, which adopt a moral view of the relationship between pain and behaviour.

- Pain as emotion. In the 4th Century it was taught that pain was an emotion rather than a sensation. The conflict surrounding the division of
the source of pain is evident today in some assessment tools used to
determine what part of the pain is psychogenic or somatic in origin.

- Pain as a warning. In the 17th Century, pain was said to be a warning of
  something wrong with the body. This notion led to the belief that
treatment for pain was an impediment to diagnosis, and thus dangerous

- Categorising pain. The 19th Century saw pain explained within the
  emerging parameters of the sciences of medicine - anatomy, biology and
  biochemistry. If pain could not be understood in these terms it was
  ignored

These notions of pain are still a factor in the assessment and understanding
of pain by some of the general community and also by health professionals,
including nurses.

Literature has also provided a powerful force in shaping ideas and attitudes
about pain. Pain and the pain of dying have been well represented in
literary works, carrying with them vivid descriptions:

Pain is perfect misery, the worst of evils, and,
excessive, overthrows all patience. (Milton, 1667);
Pain is a more terrible lord of mankind than even
death itself. (Schweitzer, 19th Century, cited,

Tolstoy’s much quoted and powerful story of the painful death of Ivan
Ilyich is embedded in our culture:
He wept on account of his helplessness, his terrible loneliness, the cruelty of man, the cruelty of God and the absence of God. (Tolstoy, 1960, p. 271)

Such descriptions have conveyed an interpretation of pain that has contributed to the fear of cancer and pain. Historical influences have not only affected attitudes but have been inculcated into practice, evidenced by much anecdotal and empirical work which will be discussed in the following sections.

**Current Perspective**
Contemporary ways of viewing pain have been influenced in part by the past, particularly by religious beliefs and the notions of cause and effect. Some current perspectives have adopted some new values, based on new belief systems and different ways of researching the phenomenon (Quint Benoliel, 1995). They have particularly influenced health professionals and those experiencing pain. The new values and belief systems stem from new technology, which has advanced scientific knowledge related to anatomy, physiology and psychoneuroimmunology as well as alternate ways of viewing human beings and pain.

Melzack (1993) attributes the theory of pain inherited in the 20th Century to the concepts articulated by Descartes. These were influenced by the scientific method of the 17th Century and in their time gave rise to a major revolution in thinking. Descartes argued that the body worked like a machine and therefore could be studied solely through methods of physics (Melzack, 1993). Melzack argues that Descartes theory “determined the ‘facts’ as they were known up to the middle of this Century” (1993, p. 1). Descartes’ specificity theory of pain dominated much of the thinking and
therefore management of pain. This particular theory proposed that pain was an entity with specific peripheral and central components; the peripheral receptors communicating directly with the specific central components (McGuire, 1987). It did not allow for any other social or psychological experiences to influence the degree of pain felt. The pain experience was seen to be proportional to the pathology or injury. Progressively persistent research looking for pain fibres leading to a pain centre in the brain, and which gave rise to the theory of pain as a specific projection system (Melzack, 1993) is one example of the quest to isolate a single pain mechanism.

A reaction to the specificity theory of pain is pattern theory in which a number of like theories are grouped. These theories to different degrees are dependent on the role of stimulus intensity on non-specific receptors and central summation researched by Sinclair and Weddell (Melzack, 1993). The theories advanced pain theory because they described a more significant role for the spinal cord in the pain mechanism but failed to recognise a more active role for the brain as a determinate in pain. A major factor in discrediting both the specificity and pattern theories is Melzack and Wall’s theory of the gate control mechanism of pain (Melzack & Wall, 1965) because it described a more complex mechanism in particular a more advanced role of the brain in pain perception. The gate control theory of pain was the beginning of viewing pain from a broader perspective.

**The Gate Control Theory of Pain**

The gate control theory of pain progressed from research that challenged both the specificity and the pattern theories of pain, in particular the role of the brain in pain perception (Melzack, 1993). Wall’s early research demonstrated that a feedback mechanism for small and large nerve fibres
existed and that impulses were modulated in the substantia gelatinosa (Melzack & Wall, 1965). This work contributed greatly to the gate control theory of pain developed by Melzack and Wall (1965). The gate control theory proposed a gating mechanism at the substantia gelatinosa in the dorsal horn, dependent on a balance of excitatory and inhibitory activity between the myelinated and unmyelinated primary afferents and the descending central pathways. The theory hypothesised a perception of pain modified by cognitive, sensory and affective interaction, and has had an enormous influence on pain research and treatment. The gate control theory marked the beginning of a wider discussion about pain as a complex experience, by shifting the notion of pain as a peripheral entity to a complex interaction involving many variables and modulated by systems in the spinal cord and brain (Melzack, 1993).

The concept of the pain experience continued to evolve, as professionals from disciplines other than medicine became involved, asking different questions about the phenomenon of pain. As a result, the International Association for Study of Pain (IASP) was the first to formally acknowledge the complexity of pain by publishing a definition to reflect this and which continues to have international acceptance:

Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage. (IASP 1979, p. 250)

This definition of pain was and is important because it is remains the only internationally acceptable definition of pain, although anecdotal evidence suggests that with newer understandings has come the need to revise this
definition. There has been a great deal of progress in terms of what Melzack describes as a “somesthetic experience” (1993, p. 4). Melzack’s research has led him to a beginning understanding of the complex brain and spinal mechanisms underlying acute and chronic pain. He suggests, radically, that “you don’t need a body to feel a body … the brain itself can generate every quality of experience which is normally triggered by sensory input…” (1993, p. 4). This experience often occurs with phantom limb pain.

The Medical Model
Progress in advancing knowledge about the complex system underlying the complex feeling of pain has by no means been universal. As Melzack points out, the legacy of Descartes’ philosophy has “permeated our concepts about physiology and anatomy that we still cannot escape” (Melzack, 1993, pp. 1-2). Many in the medical and nursing fraternities continue to accept a model of disease and illness based on a view that relies solely on objective data in assessment and treatment (Quint Benoliel, 1995). This is despite efforts by a range of health professionals and acknowledgement of more enlightened views such as the pain definition by IASP. Parker (1991) traces the connection between Descartes philosophy, or Cartesianism, and a medicalised view of the person with illness. This connection has been described within a “biomedical format and all life processes reduced to these terms” (Parker, 1991, p. 301). This view is directly related to Descartes’ philosophy in which a person is objectified and “treated as if they are independent of social and environment contexts” (Parker, 1991, p. 301).

Arguments have been presented by nurses supporting the view that a biomedical format or medical model, on the one hand, is occasionally compatible with nurses’ values (Reed & Watson, 1994), and on the other that it has not influenced nursing practice, only nursing theory (Whall,
1989). The pain literature suggests nursing practice of pain management has been slow to embrace a more holistic view of a person with pain (Donovan, 1989; Jacox, 1979; McGuire 1992). McCaffery and Beebe (1989, 1999) discussed the myths commonly held by health professionals about pain and people with pain. These myths centred on the invisibility of pain, and succeeded in creating doubt about the existence and severity of pain in those who were assessing and treating the person with pain. McCaffery and Beebe’s first edition of the text (1989) has been published widely and has been accepted by nurses as an educational text that suggests an era of changing attitudes and beliefs that has now been replaced by a second edition by McCaffery and Pasero (1999). The gate control theory opened the way for influences in nursing such as the meaning of pain and past experiences, to be acknowledged and assessed in relation to their impact on the subjective experience of pain. An element of assessment then, is to find out what the patient knows in relation to the subjective influences that contribute to the expression of pain in each individual.

**Recent Advances**

Wide ranging research continues to advance understanding about the mechanisms involved in the phenomenon of pain, and recent research takes understanding of pain mechanisms to areas not even conceived of two decades ago. Recent studies demonstrate the plasticity of neurons (Woolf & Salter, 2000) and the mechanisms that support secondary affect or the affective dimension of pain (Price, 2000). Woolf and Salter have developed a conceptual framework that accounts for the plasticity in primary sensory and dorsal horn neurons. Plasticity of these neurons enables them to change their function, chemical profile, or structure. These functions in turn contribute to the overall expression of pain hypersensitivity. The mechanisms are complex and the particular sequence and patterns of
activation, modulation or modification that occurs in the periphery and the central nervous system determine their duration accounting for some experiences of prolonged and intractable pain. Price (2000) offers a review of the research and literature that deals with pain affect. He suggests that enough research has been conducted to provide evidence for "serial interactions between sensory, unpleasantness, and secondary affective dimensions of pain and their neural mechanisms" (2000, p. 1769). He describes secondary affect as the emotional feelings generated by the implications of having pain. This work closely parallels the contention that people know their own pain from a philosophical perspective, although it does not fully account for this perspective. It gives new hope, that a convergence of discipline perspectives may in the future offer a better understanding of pain.

CANCER PAIN

A range of philosophical and theoretical orientations has been presented as a way to explain the complex interaction called pain (Ahles et al, 1983; Bonica 1967; Buytendijk, 1962 a, b; Jacox & Stewart 1973; McGuire 1985; Sternbach, 1968). Cancer pain came to be seen as a different entity to non-malignant pain because of the factors related to a sometimes chronic illness which was potentially fatal. Treatment of cancer pain was often secondary to the treatment of the disease and usually unimodal (Cleeland, 1993). Patients with cancer can suffer from a range of symptoms that range from physical to psychological, social and emotional effects. The incidence of cancer pain that is unrelieved is of great concern. The World Health Organisation (WHO, 1996) has identified that cancer pain requires emphasis independent of other types of pain. WHO has also identified that cancer pain can be controlled in 70-90% of patients using simple treatments, and has
developed and promoted a simple approach to the treatment of cancer pain with the introduction to the analgesic ladder. This approach has been well received by many agencies and incorporated into specific, local cancer pain management protocols. However, it has been reported that often patients with cancer pain continue to experience unacceptable [to them] levels of pain, with only 50% of patients in western countries achieving good control (Hanks, 1995). One of the problems contributing to this situation, and discussed later in the chapter is with assessment of pain and the factors that contribute to poor assessment.

Similarly, Portenoy and Lesage (1999) indicate that the incidence of chronic pain in people undergoing active treatment for cancer is 30-50% and 70-90% for those with advanced disease. Moreover, they assert that prospective surveys indicate that 90% of all cancer patients could attain adequate pain relief with simple drug treatment, but this is not achieved in practice. The reasons for this will be discussed later in the chapter. Another distinction made between cancer pain and non-cancer pain identified an important relationship, that between pain, illness and death. People with cancer pain were not only entering a world wherein pain concepts were primarily disease related, but where the processes around death and dying were often silent - a major factor for someone with cancer and in pain.

Armstrong (1987) disputes the notion of silence in relation to death and dying, especially in relation to illness and pain. However, May’s (1993) argument that cultural practices such as the sick being moved to a hospital to die and the existence among professional staff of a strong reluctance to discuss issues related to dying, do not support Armstrong’s thesis. Silence related to the dying process can have an enormous impact on the nature of the pain that is experienced (McCaffery & Beebe, 1989). Silence
surrounding death was not the only problem confronting those in pain. The silence and language of pain itself was at the centre of all interpretations of another person’s pain.

Scarry (1985) identifies the problem of language that surrounds pain and which gives rise to the inexpressible qualities and understandings of pain. The inability to express physical pain can be accounted for in a number of ways, including a decline in cognitive or physical ability. However, the major underlying problem is one of language. Sternbach (1968), Degenaar (1979), Schrag (1982) and Scarry (1985) among others recognised the deficiency of language in giving voice to a person’s pain. Such a deficiency has given rise to both political and perceptual complications, which Scarry (1985) describes in depth. In other words, pain is not objectified, is not visible and so has had difficulty becoming legitimised as part of the public discourse and, therefore, public consciousness and acceptance. An example of the discontinuity between private pain and public acceptance is found in the story of Maggie Peters, one of the participants in this study. Maggie knew her pain was related to cancer long before a diagnosis was made. However, her concerns were dismissed and subsequently she felt labelled as a malingerer by the doctors and her family.

Aristotle described pain as arising from outside the body, from within the body or within the soul (Scarry 1985), recognising what has taken a long time to rediscover, that pain is a pervasive entity. The pervasiveness of pain cannot be reflected easily because of the deficit of the language surrounding it. Scarry cautions that pain has no voice, but if and when it at last finds a voice, it begins to tell a story, a story of living and being in a world of pain (Scarry, 1985). This story sometimes expresses the inner knowing that gives rise to a frustrated, inarticulate acceptance that pain is more than a
number on a line or a few descriptors, important in diagnosing and treating at times, but not in rendering understanding and compassion or completing a full pain assessment. The developments in understanding pain from the work of Melzack and Wall, the research that contributed to their gate control theory and the work that has flowed from it, are slowly providing a voice in which pain can be expressed. In doing so, it is moving further away from Descartes’ theories of specificity and the singular relationship between mind and body.

Many people with cancer pain live in a world of paradoxes, contradictions and many unknowns, and their dying envelopes it all. Melzack and Wall’s (1965) research supports a wider view of pain, generating further research which has attempted to gain access to the personal language of pain through a more comprehensive assessment.

**The Multimodal Nature of Pain**

Pain can result directly or indirectly from the cancer, from the treatment or be unrelated to the cancer or the treatment. Additionally, there can be multiple sites of pain. Research (Twycross & Fairfield, 1982) has demonstrated that one person with cancer may have pain that originates from one or more of these sources of pain. A patient with pain may have a history of substance abuse and therefore require a different approach to management. The sources of pain may change from time to time as will the nature, severity, duration and location (Twycross, 1995). In addition, the concept of “total suffering” has developed to express the relationship between a number of different factors and pain. These other factors include other physical symptoms, psychological problems, social difficulties, cultural factors and spiritual concerns (Woodruff, 1996), and will be discussed below. Woodruff (1990) makes the point that these interdependent
relationships indicate that attempts to relieve pain will not necessarily alleviate all the suffering, which may be manifest by increased pain levels.

Miaskowski (1993) and Twycross (1995), amongst others, identify the importance of assessment to determine the cause of the pain as well as other factors that may be involved because this will greatly influence treatment. Woolf and Slater (2000) identify three types of pain; physiological, inflammatory and neuropathic, and each type of pain may need to be treated differently, although they may occur together. Opioid and non-opioid analgesia are the mainstay of cancer pain management usually in combination with adjuvant medication, such as non-steroidal anti-inflammatory, anti-depressant, anticonvulsant and/or steroidal drugs. Non-pharmacological approaches are an important contribution to pain management. Miaskowski (1993) suggests these approaches should be carefully selected and are generally used in conjunction with pharmacological strategies. Non-pharmacological strategies include: massage, positioning, heat packs, cold packs, transcutaneous electrical nerve stimulation (TENS), distraction/relaxation techniques, hypnosis, guided imagery, biofeedback, art and music therapy.

THE MULTIDIMENSIONAL NATURE OF CANCER PAIN
Ahles, Blanchard and Ruckdeschel (1983) identified multiple dimensions of pain as physiological (organic aetiology), sensory (intensity, location, quality), affective, (depression and anxiety), cognitive (thought processes and self perception) and behavioural (behaviour related to pain or its relief). They reviewed research investigating one or more of these dimensions and found the research literature limited by methodological problems, a failure to evaluate effectively and a dearth of systematic studies describing cancer pain. Ahles and his colleagues (1983) assessed each of these dimensions of
the cancer pain experience using a control group of pain free patients with cancer and as a result proposed the five dimensions identified above, as being part of the whole experience of cancer pain.

McGuire (1987) extended these concepts to include other factors impinging on each of the five dimensions and added the sociocultural dimension. This sixth dimension incorporates personal characteristics such as, ethnic background, social support, familial pain models and patterns of interpersonal communication. The concepts underlying such a model were not to reduce the pain experience to its component parts, but rather to be able to identify and treat factors contributing to the overall experience of pain with better outcomes for the patient. McGuire cautions nurses about misusing the model, saying, “although pain has many individual components, it must be viewed as an interrelated and interactive whole” (1987, p. 15), consistent with the perspective of nursing which identifies a person as a whole and not just the sum of his/her parts. Nursing research, but not always nursing practice responded to this model. Arathuzik (1991) and Geach (1987) each examined the area of coping with cancer pain identified by McGuire (1992) as a component of the cognitive dimension. Each has a different perspective and their studies are used to illustrate some difficulties that have been encountered with the interpretation of the categorisation of cancer pain.

Arathuzik (1991) used a quantitative methodology to identify coping strategies of patients with cancer pain and the relationship between the cognitive and affective appraisal of cancer pain. A quantitative methodology requires a circumscribed view of the concepts of pain, coping and appraisal, and a preconceived intention of cause and effect. This is not consistent with the holistic nature of nursing or the multidimensional model
of cancer pain. The tools used, identified variables considered to be consistent with pain and coping as assessed by professionals. The purpose of the multidimensional model is to acquire information related to the patients’ understanding of their pain and to move away from the professional as the final authority on another person’s pain (McCaffery, 1979; McCaffery & Beebe 1989). Given that pain is a unique experience, which Arathuzik acknowledged, her study inhibits uniqueness of interpretation from the participants.

The variables Arathuzik (1991) used included depression, hostility and anxiety. It is possible the patients tested in the study may not have self diagnosed any of these conditions, which would alter the meaning or significance of the pain for a person, a factor that Arathuzik built into her framework. Within a Heideggarian framework, understanding or significance is dependent on interpretation rooted in personal meaning of the situation. This interpretation is quite likely to be different from that of a researcher or carer. Although Arathuzik’s tool was designed to ‘diagnose’ these variables, it may not have captured them accurately for each person. Depression, hostility and anxiety may not have been identified by the research participants as factors that influenced their pain. The variables may not have impacted on the individual meaning of pain unless they were considered to be an influencing factor by the person with pain (Tishelman, Taube & Sachs, 1991).

Geach (1987) argues for a separation of pain from coping both theoretically and in practice. She justifies this by proposing that understanding pain quo pain is the goal of the nurse and the patient is separate from their pain existentially and practically, “it should be understood that there is no objection to assessing self-image, inner resources and so on; but these
assessments are relevant to understanding the person in pain rather than the pain itself" (1987, p. 13). Geach’s view is in opposition to that expressed by many pain experts (Ahles, Blanchard & Ruchdeschel, 1983; McCaffery, 1979; McGuire 1987; Melzack, 1982; Tearnan & Ward, 1992).

The multidimensional model, has given rise to a number of studies that have in some way explored the dimensions of cancer pain and thereby extended knowledge and understanding about cancer pain. These studies have:

- examined psychological variables in contributing to pain control (Turk & Feldham, 1992);

- critically reviewed the methodology researching the concept of coping in cancer pain (Jensen et al., 1991);

- examined the meaning of pain/illness and the subsequent impact on cognitive processes (Barkwell, 1991; Tishelman, Taube & Sachs, 1991); and

- attempted to generate a causal relationship with biobehavioural factors and cancer pain (Dalton & Feuerstein, 1988).

It is obvious then, that pain cannot be isolated as a separate event and the work being done in psychoneuroimmunology is evidence of that.

Psychoneuroimmunology refers to the study of the relationships between the nervous system, immune system and states of mind (Varela, 1997). These links are concerned with states of health and disease. Research by Pert (1993) has demonstrated that emotions and thoughts are created by
neuropeptides that are transferred to cell membrane receptors; receptors found in almost all cells of the body. The relationship between the body and mind in health and disease is reinforced by the fact that the same neuropeptides have been found in the brain and body, suggesting a network of mind and emotion that is inseparable from the body (Kemeny, 1993; Pert, 1993). Literature related to psychoneuroimmunology and the psychophysiological impact of pain, demonstrate the nature of the relationship between pain and the body and mind. Johnson (1996) illustrates this relationship by demonstrating that adverse psychological mechanisms of pain conditions can produce muscle spasms, visceral dysfunction, local vasoconstriction and the release of neurohumoral substances. Other research in psychoneuroimmunology (Levy et al., 1990; Bovbjerg, 1991) raise the importance of addressing psychosocial issues for people with cancer pain, because of the negative effects these issues have on the development and progression of cancer. Psychoneuroimmunological research also supports the view that pain negatively affects the progression of metastatic disease (Page & Ben–Eliyahu, 1997).

Research in this area has also contributed to knowledge of the relationship between pain and suffering. Chapman and Gavrin describe suffering as,

A threat or damage to the integrity of the self, entails a disparity between what one expects of one's self and what one does or is (1999, p. 2234).

They also suggest that uncontrollable pain creates such a disparity and can result in changes to a sense of self. One mechanism Chapman and Gavrin (1999) suggest that may account for this is if nociception or neuropathy persists, then neuroendocrine dysregulation supervenes. Many effects of suffering resemble depression although suffering is a broader concept that is
not reliant on self-blame but is dependent on mindfulness of the future (Chapman & Gavrin, 1999).

Studies such as these have contributed to raising the profile of cancer pain within health care settings, slightly shifting the emphasis from cure at the expense of pain control, which Cleeland (1993) identified as a priority. In the process, the importance of assessment became clear as it developed a separate focus within research.

Knowledge and understanding of the physiological mechanisms of pain has progressed a great deal in the last three decades and has led to greater appreciation of the many factors that impinge on the subjective experience of pain. The complexities within the experience require a range of different approaches for another person to understand and assist with the management of a person’s cancer pain. Pain is a personal event with the experiencing person’s response reflecting a knowing and understanding that is not always able to be articulated. Pain assessment is a means by which some of the personal knowing and understanding can be unlocked, in addition to obtaining more quantifiable information about a person’s pain.

PAIN ASSESSMENT

Pain theory described above has influenced pain management through the understanding and knowledge that the assessor has of the pain mechanisms. The development of pain theory over time from a biomedical view to a multidimensional perspective has provided the opportunity to develop better assessment strategies that include quantitative and qualitative aspects of pain defined within the multidimensional model of pain, as well as improved treatment regimes. Assessment is the link between the pain
experience and appropriate management that meets the experiencing person’s needs. Pain assessment is not an automated task that is the same for each person with pain, because “…pain is always subjective and patients’ pain is what they say it is and not what others think it ought to be” (Woodruff, 1996, p.18). Assessment is a responsive approach to determine the individual collective factors underlying each person’s pain and is an important role for the nurse. Somerville contends that if someone is in pain, the question should be asked, “why is a person left in pain?” (1994, p. 42). In supporting this position, she identifies the temporal nature of the role of the health professional in that “… the questions we are now asking are often more indicative of the ways in which we will act in the future than the responses we are giving in the present, which tend to reflect the past” (p. 42). In acknowledging this dynamic, the complex reality of the ‘space’ between the patient and the nurse becomes clearer, and with it the role of the nurse in understanding self, patient and the mutual dynamic.

THE NURSE/PATIENT CONTEXT - ASSESSMENT

Pain assessment was initially identified as an important function for nurses by Jacox (1979). Jacox conceptualised the assessment process as being formidable because, “the ability of one person to interpret accurately what is felt by another is complicated when the attitudes of the assessor and the person being assessed differ” (1979, p. 895). These were enlightening thoughts, given the era in which the paper was written, when pain medication was carefully controlled, dosage and administration being more dependent on strict regimes than individual needs, and assessment of pain was restricted to quantifiable measures. Jacox urged nurses to listen to the person experiencing pain, not just observe them, because she believed pain was a subjective experience.
Assessment is the most important activity in attempting to gain an understanding of another person's pain. Inadequate assessment of the individual pain experience has been cited as a reason for inadequate treatment of pain by nurses (Harrison, 1991; McCaffery & Beebe, 1989). The patient/nurse dyad is the context within which assessment occurs and historical and current perspectives will impact on this context. Patients, who find they have been thrust into a foreign world of pain, illness and institutional culture, will be dependent on the assessment made of their pain. Understanding based on an assessment process is integral to the management of their pain. As pain is experienced differently for each person the outcome of each assessment will be different, which gives rise to the expression "pain is what the person says it is". Approaches to this process will vary and be dependent in part on the assessor's philosophy. As discussed above, a medical model process of assessment has a unidimensional approach. In contrast to this is the multidimensional model of cancer pain, which offers the potential for a more complete assessment.

The value of a multidimensional model of pain is twofold: it has the potential to advance understanding of another person's pain and it can be used as a tool for gathering information in pain assessment. There are two sides to the use of such a tool: it can provide a more advanced approach to understanding a person with pain and thus being more consistent with developments in pain theory; or it can become routinised and miss the uniqueness of a person with pain. However, it is not clear how nurses undertake assessments, although the literature identifies barriers to nurses' pain assessment, which further complicates the process.
ASSESSMENT - THE PROCESS

The pain literature abounds with work on pain assessment, however there is not a great deal of evidence to demonstrate the incidence or the format of nurses' pain assessment. Jackson and Mannix (1997) argue that formal pain assessment by nurses is not widely practiced. One study by Kennedy and Rooney (1991) found that 85% of hospices used a pain assessment tool although each comprised different dimensions of the multidimensional model. Not all hospices used all the dimensions for assessing pain and although the tools were part of the accreditation requirement there was no evidence to indicate that nurses used the tool. Kennedy and Rooney’s findings are supported by Sloan et al., (1999) who undertook performance based testing of twenty-seven hospice nurses. The study primarily related to the pain assessment skills of, and management recommendations by, the nurses. The testing did not examine a multidimensional assessment approach although a range of physiological indicators was included, with the result that most hospice nurses were judged to be competent in the assessment of severe pain, with some deficits noted. Given the small number of nurses in the sample a Type II error should be considered in the evaluation of the results.

Pearce (1993) found in her small study that nurses were either not using, or using inappropriately, pain assessment tools in a community setting, although this improved with specific continuing programs. However, the effectiveness over time of education programs is challenged by a study that specifically explored the long-term effects of education programs on nurses' pain assessment practices (Howell et al., 2000). This study demonstrated improvement in knowledge and attitudes about pain assessment and management immediately following the education intervention and a decrease three months following in most of the items in the testing
instrument. The conclusion drawn was that better educational and organisational support was required to influence better pain assessment and management practices. Consideration was not given to the professional responsibility of nurses to maintain adequate knowledge and assessment skills.

An Australian study by McCaffery and Ferrell (1994) examined nurses' assessment of pain intensity and selection of dose appropriate analgesia. The study found the nurses had inadequate knowledge about fundamental issues of assessment. A follow-up review by McCaffery and Ferrell (1997) revealed that knowledge deficits in assessment and management of pain, remains a problem although they felt that education programs had probably been beneficial, although their review was not able to support this contention. Heye and Goddard (1999) also found that misconceptions by nurses about many aspects of pain management and undermedication of pain has not changed in 20 years despite increases in education designed to improve patient outcomes. They found that patient and nurse characteristics contributed to poor pain management making pain assessment a complex process. Wilkinson's study (1991) found that nurses' assessments of cancer pain were superficial and did not explore the depth or meaning of the pain for the individual patient.

Grossman (1994) has taken a physician's perspective and suggested there may be informal and formal use of the multidimensional model with little formal use in the way of documentation. He cited as reasons for this: the complexity of the experience of cancer pain based on the subjective nature of pain; physicians who are ill-equipped to evaluate cancer pain and the constant re-evaluation required, presenting difficult choices for the physician. My own experience supports anecdotally, evidence that the
model is not used comprehensively and may be used in part on an informal basis.

From the literature it would seem the multidimensional model provides an opportunity for important change in direction for understanding cancer pain. Unfortunately this model has been used primarily as a research and educational tool rather than as a practical tool for clinicians. It has opened new possibilities in the world of pain in which patients find themselves but also has the potential to inadvertently reinforce the notion of categories within the pain experience. The possibility that the category may become more important than the person in pain may well be realised with the potential of reverting to a biomedical approach. The modulation mechanism in the gate control theory of pain and the psychoneuroimmunological factor in the pain experience underpin such a relationship. Often though, pain is measured rather than assessed. McGuire (1984a, 1985, 1987, & 1992) has contributed much to understanding pain assessment and specifically related cancer pain to multidimensional assessment. She identifies a distinction between measurement and assessment of cancer pain, as quantitative and qualitative respectively, both being important in understanding the pain experience. She states that “...assessment is the key to relief of pain” (1992, p.317). However, the visual analogue scale remains the most common assessment made of a person’s pain, possibly due to the difficulties encountered using more in-depth assessment tools in the clinical setting, and with the specific characteristics of cancer pain (Deschamps, Band & Coldman, 1988).

Despite the fact that assessment of cancer pain has not automatically followed the advances in science about pain, a plethora of assessment and measurement tools have been developed to capture the components of
cancer pain (Donovan, 1989). Questionnaires developed over the last three decades in an attempt to better assess pain and to include the multidimensional aspects of pain, include the McGill-Melzack Pain Questionnaire (MPQ) and the Brief Pain Inventory (BPI). Melzach & Torgerson (Melzack & Torgerson, 1971) began work on the MPQ, which was not specifically related to cancer pain, although used in that area. Wilke et al., (1990) conducted a meta-analysis of the MPQ and identified some problems with its use, including the fact that a number of different versions were being used making its effectiveness difficult to evaluate, and administrative instructions for its use do not exist. It was found that although Melzack and Torgerson designed the tool to administered verbally (Melzack, 1975) it was often administered in a written format. McGuire (1984b) found it took longer to administer for people with cancer pain and Shannon et al. (1995) describe the limitations of patients with advanced cancer to be able to use a range of common assessment instruments, including the MPQ.

Shannon and her colleagues identified that self-report of pain is the most valuable form of assessment, although a perception of self-report of pain usually referred only to its intensity. Zaza, Reyno, and Moulin (2000) researched the generalisability of the use of the multidimensional pain inventory (MPI) in patients with chronic cancer-related pain. The inventory seeks to identify patient profiles according to three taxonomies, and are labelled Dysfunctional (DYS), Adaptive Copers (AC), and Interpersonally Distressed (ID). Their research suggested that only two profiles might better describe cancer patients, because the ID category that reflected social support may not be necessary for cancer patients. A point they make quite strongly is that better classification of cancer patients will lead to more tailored pain management and quality of life. However, as with many
classifications of people and their pain in particular, the meaning of the event or situation may well be lost and therefore understanding the person will not be a functional part of practice.

Cleeland et al. (1983) developed the Wisconsin Brief Pain Questionnaire, later known as the Brief Pain Inventory, based on the McGill Questionnaire, although adapted for cancer patients. As its name suggests it was a briefer tool designed to be more adaptable in the clinical setting. In response to pain theory development Bruera et al. (1989) and Bruera et al. (1991) have identified a process for cancer pain and symptom assessment in the clinical setting. The tool that has was developed the Edmonton Symptom Assessment Tool measures pain and its relationship with other symptoms. These tools have not been well evaluated and as has been discussed earlier, there is no evidence that there is widespread use of them by nurses in the area of cancer pain, and if they are, that they are using them effectively.

Evidence exists, however, to claim that nurses and patients have different perceptions of the pain being experienced (Grossman et al., 1991; Teske, Dant & Cleeland, 1983), which may be the result of the many barriers that have been identified within the nurse/patient interaction.

**BARRIERS TO ASSESSMENT**

Understanding barriers to pain assessment is important in improving the process of pain assessment, given the importance placed on assessment in the management of pain. Nurses' assessment of patients with cancer pain have been the subject of research studies in an attempt to improve the accuracy, interpretation and understanding of another person's pain, and therefore the management of pain. Studies to date have focused on the determinants (Halfens, Evers & Abu-Saad, 1990; Harrison, 1991) and the
barriers to effective assessment of cancer pain (Ferrell, McCaffery & Grant, 1991; Stratton-Hill, 1993; Vortherms, Ryan & Ward, 1992). In addition, inadequate knowledge (McCaffery & Ferrell, 1994) or decision making skills in analgesic administration (Sheidler et al., 1992) have also been identified in contributing to ineffective assessment and pain management. Most of these studies have not used assessments made in the course of clinical practice, but have used arbitrary situations as the setting for their studies thus diminishing the importance of individual experience of pain and subsequent individual assessment.

In addition, nurse characteristics can influence the accuracy and type of assessment performed (Halfens, Evers & Abu-Saad, 1990). The study by Halfen, Evers and Abu-Saad (1990) refers to nursing experience as one characteristic that impacts on accuracy and type of assessment. Experience was measured by length of time as a nurse. However, student nurses and registered nurses with different levels of education were the research participants, suggesting that educational level may have been a variable in the study and for which there was no control. Educational level could be deemed to be different to level of experience referred to by Halfen. Harrison (1991) suggests pain assessments are more accurately performed by more experienced nurses, however, she does not define 'accurate' or 'experience'.

Bonica (1985) researched over 2000 patients and found 50-80% had inadequate pain relief. He also found lack of education was the most common reason. This unfortunately was the case almost ten years later when McCaffery & Ferrell (1994) surveyed over 4000 nurses in practice settings in America, Canada and Australia and found a lack of knowledge relating to analgesic administration and pain assessment was common.
Poor decision making skills of nurses were found to be a major factor in inadequate pain relief in studies by Ferrell, McCaffery and Grant (1991) and Shiedler et al. (1992). In the latter study there were inherent limitations, identified by the authors as faulty design, convenience sampling and use of hypothetical vignettes. The study was unable to identify the factors contributing to poor decision making skills. Whereas the study by Ferrell, McCaffery and Grant (1991) which used a descriptive survey method, identified factors that contributed to nurses’ decisions about pain assessment and relief. An example from this study indicates that 91% of nurses surveyed asked the patient about their pain but only 45% of nurses regarded it as the most influential factor in determining pain intensity. Barriers to pain relief involving four groups of people intimately connected with pain assessment and management; patient, family, physician and nurse were identified in the study. The barriers specifically related to lack of knowledge and lack of co-operation, indicating a need for nurses to have a role in education of patients and families as well as a better understanding of patients and families.

Stratton Hill (1993) classified the barriers to adequate cancer pain relief into three categories; societal - cultural and attitudinal, knowledge deficits, and influence of regulations. Glajchen et al. (1995) identified patient psychosocial factors that complicate cancer pain assessment and that include: mood state - confusion, depression, fatigue, tension, general mood disturbance, interference with life; activity and life enjoyment; and physician-patient communication barriers. These indicators were found to be related to patient education level and the researchers suggested that they be included in assessment of cancer pain. Redmond (1998) explored barriers to effective pain management and identified a number of reasons for
these barriers. She categorised them according to their origin, into health professionals, patients and family members, and the healthcare system. This analysis has extended the notion of barriers to include the role of others in the breakdown of good pain management. However, the reasons attributed to health professionals and nurses in particular, are unchanged from other analyses cited above, and include, poor decision making, poor pain assessments, poor knowledge, underutilisation of pain management skills, and myths and misconceptions about opioids. The reasons attributed to patients and family include reluctance to report pain and non-compliance with treatment.

The patient/family factor is interesting because, an assessment by the nurse should identify the misconceptions, social, cultural and other factors that lead to both non-compliance and reluctance to report pain. A significant factor in poor assessment is that patients often have been reluctant to report pain for a range of reasons. Garro (1990) found that stoicism was a valued attribute in some cultures and so reporting pain would not be consistent with that attitude. Yates et al. (1995) studied older people living in residential care facilities and found that they did not report pain because they held beliefs that pain was both inevitable and to a large extent uncontrollable. Thomason et al. (1998) examined the barriers to cancer pain management and assessment from the patient’s perspective and found through interview of the participants that stoicism and fatalism were significant factors in barriers to good pain relief. This, despite the fact that the participants had recent communication with their doctor (52%) and nurse (41%). It is these meanings of pain that should be uncovered by the nurse but will not be identified if nurses are unable to communicate and understand how a person knows their own pain.
It has been suggested that pain assessment often ignores the patient’s self report of pain (Ferrell et al., 1991) and that nurses often lack skills or have difficulty in communicating with patients who have cancer (Wilkinson, 1991; Heaven & Maguire 1996). Wilkinson (1991) found that nurses develop blocking behaviours when they communicate with their patients who have cancer, thus contributing to a poor outcome for the patient. Another concern identified by Williams et al. (2000) is the common use of visual analogue scale (VAS) and numerical rating scale (NRS) instruments that measure pain. Williams and her colleagues researched the use of these tools with people with chronic pain and found that they did not adequately convey the subjective attributes of pain. In fact the tools were active in hiding the personal meanings of pain.

As described above, pain education for nurses has not been found to be entirely effective, although lack of knowledge was identified as a contributing factor in poor assessment (McCaffery & Ferrell, 1994). Heye and Goddard, (1999) suggest that developing education programs in pain assessment and management is difficult because of the wide ranging attitudes, knowledge and experience that nurses have. They have adapted Giepp’s model (1992) of ethical decision making about pain to the development of an education program for nurses, and which incorporates patient and nurse factors in the process. The resulting program is an improvement on many educational activities developed for nurses, however, there is no mention of the exploration of the meaning of pain for the person, which underpins the interaction between the patient and the nurse about being-in-pain. There is also no application to undergraduate education, which is also vital in reducing barriers to assessment and management of pain.
Inadequate or absent assessment and documentation is considered to be the main problem in poor management of pain (Livneh, Garber, & Shaevich, 1998). Livneh et al. (1998) assert that despite education and training, good pain management is still not being achieved in the majority of people with cancer pain. They examined medical and nursing records of thirty-seven patients in sixteen oncology wards, and conducted a telephone survey of sixteen charge nurses and concluded that none of the units participating in the survey conducted systematic documentation or follow-up of the patient’s pain and its treatment. The survey report does not identify the conditions under which the telephone interviews were conducted and presumably the areas were busy oncology units where the nurse may have been under pressure to conclude the interview. The results from the interviews may have been distorted as a result although were supported by the ward documentation. Given that pain is a major consideration in patient care in an oncology unit, these results, if accurate and representative, are disturbing.

It is apparent many factors operate either individually or collectively, either within the world of the nurse or the world of the patient, to influence nurses in their assessments. The primary notion that pain is subjective and the experiencing person is the one who knows most about his or her own pain, suggests a next step is to find out the ways this pain is known by the person experiencing it.

**AN ASSESSMENT MODEL**

The literature relating to pain and the problems leading to poor pain management discussed above, lends itself to the development of a model that characterises the aspects of pain management that are problematic and should be included in any assessment of pain. Such a model (Figure 1) would include components that are interrelated and which include concepts of
multidimensional and multimodal aspects of pain. The components include: assessment; variable individual (subjective) pain; the pervasive nature of pain; and pain language.

![Figure 1: An Assessment Model for Cancer Pain](image)

Each of these areas has been discussed above and together provide a wider perspective that is not limited to a multidimensional approach, because the silence of pain that does not know a language, and the pervasiveness of pain
for which it is difficult to find descriptors, are addressed. Importantly it
recognises the individual wholeness of pain that has a specific meaning based
on the person’s way of being. The multidimensional way of assessing pain
may be limited by the parameters set around the its structure, language and
administration, although its concepts can be utilised within the model
presented. This new model also better reflects an existential approach to
assessment based on Heidegger’s concepts discussed in chapter three.

The multimodal and psychoneuroimmunological aspects of pain can also be
incorporated in the pervasive aspects of pain, and the individuality of pain.
The language of pain encompasses the other two components and allows the
descriptive language but also the personal language of pain. Assessment is
the key to unlocking the personal meaning held within each of the other
components. This model is designed to be utilised as a trigger for
communication for the nurse or health professional rather than a tick sheet
approach. It is only through appropriate reflection and communication that
pain within the existence of the person can be heard.

THE PALLIATIVE CARE CONTEXT
This study is set within a palliative care model of care, either within the
community or in an established hospice. However, the notion of palliative
care is not framed specifically by the fact that a palliative care service of
whatever type, is involved, rather that the care delivered follows established
principles and philosophy of care attributed to palliative care. These
principles of management of the person with primarily a terminal illness
emphasise the comfort and quality of life of the person involved. It is
totally person-centred and its practice includes the whole family, however
defined. The World Health Organisation has described palliative care as:
Palliative care is the active total care of patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms, and of psychological, social and spiritual problems is paramount. The goal of palliative care is achievement of the best possible quality of life for patients and their families. Many aspects of palliative care are also applicable earlier in the course of the illness, in conjunction with anticancer treatment. (WHO, 1990).

Further, WHO defines the principles which flow from this philosophy and they include:

- affirms life and regards dying as a normal process;
- neither hastens nor postpones death;
- provides relief from pain and other distressing symptoms;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help patients live as actively as possible until death;
- offers a support system to help the family cope during the patient's illness and in their own bereavement (WHO, 1990).

A more succinct definition that encompasses the spirit and intent of palliative care states, “Palliative Care is specialised health care of dying people aiming to maximise quality of life, and assist families and carers during and after death” (Palliative Care Australia, 1998). This philosophy and its principles have universal acceptance, although criticisms leveled at palliative care include that it is ‘elitist’ and inaccessible to many people (Aranda & O'Connor, 1990), and that it does not account for spiritual and
cultural differences especially in relation to the fundamental concepts of palliative care regarding such as terms as, "‘individual’, ‘independence’, ‘autonomy’, ‘quality of life’, etc. (Kanitsaki, 1998, p. 32).

As a result of contemporary healthcare practices and political critiques, a matrix of concerns, debates and directions has enveloped the provision of modern palliative care practices. This matrix consists of; the urgent need to address cultural differences, mainstreaming palliative care into everyday practices, and developing a body of evidence-based knowledge (Parker, 1998) that supports practices and improves outcomes for the people it is designed to help. Part of the matrix also includes having to address the needs of people with a “low tech and high touch” (Twycross, 1995, p. 3) philosophy of care that also has to meet the political requirements of “mainstream criteria of effectiveness, efficiency and competitiveness” (Rumbold, 1998, p.3). Additionally, palliative care is expected to meet increasingly complex health and social issues that merge to challenge the orthodoxy of current treatments. The difficulty for palliative care practitioners is to strike a balance between the demands made by different groups to meet seemingly different aims, while trying to meet the diverse but individual needs of people whom it is trying to help.

**Palliative Care Continuum**

From humble and unobtrusive beginnings with a mission to provide rest and respite for those who were dying and who were often neglected by society (Redpath, 1998), palliative care has now developed into a medical and nursing specialty that endeavours to provide relief from the terrible symptoms and effects associated with cancer, not the least of which is pain. Palliative care is often regarded as the ‘last resort’ when medical treatment has failed to cure the disease or illness. This concept still pervades the
thinking of health professionals and the community, although there is a
distinct movement to take palliative care beyond the care of those with a
terminal illness, where there is a need to address pain and symptoms of
illness alongside the social, emotional, psychological and spiritual needs of
an ill person and the family (Aranda & O'Connor, 1999).

One of the achievements of modern palliative care is that it has developed
and promoted the provision of more humane care for those who are dying.
It has promoted research into the management of pain especially from
cancer, although serious shortcomings in this area in particular, are still
evident (Parker, 1998). These shortcomings include the availability of
empirical evidence demonstrating the effectiveness of palliative care in care
of people who are dying and particularly in the management of cancer pain.
One study by Salisbury et al. (1999) did conclude that pain was better
managed in a hospice setting than in a conventional acute care setting.
However, because of the difficulties inherent in undertaking clinical
measurement and research in palliative care (Higginson, 1999), more studies
need to demonstrate this finding. Higginson (1999) argues that measuring
quality of life and quality of death of people who are extremely ill and frail
is difficult and rarely successful. Equally, measuring pain outcomes in this
population is also difficult because of similar difficulties such as, patient
attrition, patient recruitment, homogeneity and defining and maintaining
contrast between interventions (Higginson, 1999). There is much anecdotal
evidence by experts that supports palliative care. The dilemma remains
though that to apply an evidence based approach to palliative care practice
remains problematic and to measure outcomes in relation to developed
standards is not always possible.
However, there now exists the beginnings of measuring the effectiveness of palliative care as it relates to its primary purpose. Palliative Care Australia (1998) has introduced performance indicators for the provision of palliative care in Australia. Two of the indicators include, pain assessment and pain management. These indicators form part of a quality assurance and accreditation process that is undertaken by an independent body. As the process becomes more widespread, data collected should be able to provide better information about the effectiveness of palliative care in the management of pain, although because of the problems sighted above the level of evidence may not be high. In addition these data will not be able to provide a complete picture because the relevant indicators are very limited in data they seek. In this respect Hearn and Higginson (1999) developed a core outcome measure for palliative care, the Palliative Care Outcome Scale (POS), that has demonstrated some promise in prospectively testing palliative care for patients with advanced cancer. These measurement tools may well become increasingly important in competing for funding to provide services that are difficult to support by traditional research methodologies.

**PAIN AND PALLIATIVE CARE**

An achievement of palliative care is the provision of respite for the ethics of caring and compassion that have traditionally underpinned nursing work and are now a hallmark of palliative care. The contemporary healthcare environment is one in which efficiency, productivity, performance indicators, and resources are paramount. Where do the very real and effective practices of caring and compassion fit in such an environment? Currently palliative care is the shelter that houses such practices, but for how much longer and how do those practices help in the management of pain. Taylor (1992, 1994) and Cassell (1991) promote a view of working
with people who are in pain and suffering, that recognises an embodied person whose pain is part of the being of a person. It is this perspective that is in danger of being lost in a worldview that relies on measurement and efficiency solely. Heidegger (1971) referred to the increasing reliance of the world on technology as a ‘destitute time’. The ethos of palliative care in combination with nursing care provides the hope that people in pain and distress from their illness will find respite from their pain, whatever the cause.

An extension to the work on psychoneuroimmunology and suffering, discussed above, is seen in the limited literature relating to compassion. Two researchers in this area, Ruff, (1997) and Felten (1993) have identified the relationship between compassionate relationships and improved physiological functioning in the presence of suffering. Taking on a compassionate role places the nurse and other health professionals who work with people-in-pain in a position where they have a better understanding of the person-in-pain. Better understanding of the person-in-pain promotes healing (Cassell, 1991) and better interventions (Bruera & Watanabe, 1994).

The concept of compassion associated with palliative care has been explored by Just (1998) in relation to pain management. Just acknowledges the derivation of the word ‘compassion’ as the Latin, cum and patti that translated mean ‘to suffer with’. Through her research, Just (1997) examined the concept of compassion and its meaning and application in the management of pain, particularly in a palliative care setting. As a result, two important characteristics emerged. The first is the relationship between compassion, suffering and pain management. Despite the confusion surrounding the terms, ‘suffering’ and ‘compassion’ Just has been able to
develop a component analysis of compassion, and reports that a synthesis of this analysis supports a concept of caring for people with pain as “being with patients in their suffering and not ‘going away’” (Just, 1998, p. 63). Her research demonstrated that using compassionate intervention reduced pain levels, “thus making it possible to obtain positive results even with cancer pain which is considered intractable” (Just, 1998). The results of this research bear some similarities with the work being done in psychoneuroimmunology and pain. The issue at the heart of both areas is the individual meaning that the pain and any intervention holds for a person.

Secondly, the role of the nurse in achieving compassionate intervention in pain in palliative care is a crucial issue. Just (1998) emphasises the partnership nature of the relationship between the nurse and the patient with pain. It is the compassionate nature of this relationship that equalises the role of the nurse with that of the patient with pain. In order to achieve this partnership an understanding of the person with pain is essential. It is in this context that phenomenological assessment has been undertaken in this study.

ANOTHER LOOK
Many assessments of cancer pain are made within an institutional setting thus providing the background to further complicate the assessment process. Many institutions find themselves with shrinking resources and an increasing throughput of patients with the same or fewer staff. This environment encourages nurses to use the most expedient process and to follow the dominant institutional ‘philosophy’ or dogma as Rodgers (1991) describes it. It is not just the nurses’ working environment but the nurses’ own context of learning and experience, which influences interpretation and
understanding. Wilson argues for these ‘variables’ to be incorporated into scientific clinical studies, or we will be left with the “effects of the singer not the song” (1994, p. 258). Incorporating the patient’s world view with the nurse’s world is essential, and separation, as is often the case, creates incongruence in interpretation and understanding and is counterproductive. Copp supports the “private, subjective world of pain” and suggests nurses infer what the subjective pain experience is, although “not always correctly since inference is based on the beliefs and experiences of the viewer not the sufferer” (1985, p. 69). Assessing the subjective experience of pain from the patient’s worldview and their ways of being in that world is an important step to understanding and interpretation for the nurse. The next step for nurses is to find a method that is enabling of that process. The multidimensional model is part of that step, but requires appropriate implementation, research and openness to question and change. The incidence of cancer pain and the nurses’ lack of knowledge (McCaffery & Ferrell, 1994) is cause enough for nurses to look again at what they do and how they do it in relation to pain.

PHENOMENOLOGY OF PAIN

A phenomenological perspective of pain is not frequently discussed in relation to pain within the practice setting, although some aspects of it are implicated, without reference to the underlying philosophy. Social and/or emotional references are sometimes made about a person’s pain although often within a cause and effect framework. However, some notable exceptions to the medicalised view, and outside contemporary nursing literature, are found within the works of Buytendijk (1962a, 1962b), Degennar (1979), Kestenbaum (1982), Schrag (1982) and Olafson (1995), where attempts are made to relocate the debate within existence of the person. Taylor’s (1992, 1994) work with people with cancer pain clearly
illustrates two important issues for nurses; firstly, that philosophy, even difficult, wordy 19th and 20th century philosophies, can uncover important and specific factors relevant to nursing praxis. Secondly, her work identifies that phenomenology has a place in uncovering contextualised understanding and meaning of a person's pain, prior to appropriate nursing intervention. These approaches have endeavoured to revisit a person with pain, rather than the pain per se. Their orientation is from the person's experience as lived - their existence.

The common thread in these phenomenological descriptions is the notion of 'being-in-pain'. Being-in-pain as a modality of existence forces the observer to seek an orientation within the wider context of being-in-the-world. Buystendijk articulates this relationship: "the real meaning of pain is only manifest in the full context of the existence of man" (1962a, p.152), and "there is no pain without a preceding original attitude towards our existence as physical-being-in-the-world" (1962b, p.164). Schrag (1982) extends the relationship of pain and the existence of man, by reformulating the root metaphor of pain, commonly accepted, of inside versus outside. The metaphor refers to the distinctions made between pain as subjective experience and objective behaviour. Schrag replaces this with an existential articulation of pain as configurative with inter-relational fields of consciousness, embodiment, praxis and temporality. Making and experiencing meaning are the outcomes of such a revision within a "world horizon of concern" (1982, p. 30).

The nurse's role in assessment of the complexity of the pain phenomenon is fundamental and needs to be informed in relation to pain and existence. One way of promoting such a way of caring is through phenomenological reflection and understanding, from a practical perspective, "being able to
manage something” (Heidegger, 1962, p.183). Using a phenomenological way of ‘seeing’ allows a way of understanding how people manage being-in-the-world, whatever that world is for them at the time. At its more basic level it uncovers the world in which people exist and the level of interaction with their world. A phenomenological way of ‘seeing’ supports another perspective based on ‘the things themselves’, the heart of phenomenology.

At another level, already alluded to, phenomenological processes promote a ‘being-with’ relationship. Taylor (1994) describes this phenomenological ‘seeing’ in nursing as part of humanistic interaction whereby the nurse learns to understand the patient as person and the patient senses a human presence or caring in their world, which in turn generates a therapeutic environment. Younger (1995) also supports such a relationship and contends that it can help a person in pain find a language to voice their pain and suffering. Rogers, (1961) a proponent of Heidegger, describes the authenticity of his personal encounters with his patients as a means of assisting them to meet the challenges within their world.

Such a shift in the philosophical approach to pain, from a unidimensional to a multidimensional view, promotes a position consistent with nursing philosophy that supports a holistic view of the person. It is this latter perspective that underpins this inquiry.

SUMMARY
Many reasons exist to explain the high incidence of unrelieved pain in people with cancer and it is suggested that the individual pain experience, the pervasive nature of pain, pain language and pain assessment, each contribute variably to the problem. Due to the personal nature of pain, it
becomes important to unravel the individual dimensions of pain in order to understand pain from another person’s perspective, and importantly, from their existence. A belief in the unity of a person with their world and the ability of a person to understand and know this unity underscores the explication of ways of knowing cancer pain as one means of addressing these problems.

In the following chapter I will outline the philosophical framework that informs this study based on Heidegger’s phenomenology, and present a new perspective of knowing that is informed by Heidegger’s phenomenology.
CHAPTER 3

PHENOMENOLOGY, ONTOLOGY AND KNOWING
PHENOMENOLOGY, ONTOLOGY AND KNOWING

I have put on these masks to show you my face
Maurice English in Degenaar, 1979, p.1

PHENOMENOLOGY - A PHILOSOPHY

Phenomenology is about removing masks to see the ‘real’ face behind that which is presented to us. Degenaar (1979) uses the analogy of English’s words to explain that in order to understand another person’s pain it is necessary to penetrate the masks they have put on, to see the reality of their pain. Ortega y Gassett (1963) uses an analogy of the masks worn by trees that exemplifies the notion that whatever is under phenomenological enquiry must be uncovered for what it is and not what it may be seen to be. The mask is what has to do with a ‘thing’ – it is not the ‘thing’ itself in its own selfhood. He suggests that we need to remove the masks in order to see the reality of the tree, not the things to do with trees. Phenomenology insists on returning “to the things themselves” (Heidegger 1962, p. 58).

A number of phenomenologies exist, which have been well analysed in the literature by nurses, philosophers and academics (Benner, 1984; Crotty, 1996; Dreyfus, 1987, 1991; Koch, 1995; Morrison, 1978; Parker, 1991; Spiegleberg, 1971; Walters, 1995) and it is not the intention to repeat the analyses in this study, but rather to present Heidegger’s view of the world as it is presented in Being and Time (1926/1962) as it informs this inquiry. Two of the most well known types of phenomenology are transcendental and hermeneutic, the latter forming the framework for this study.
HEIDEGGER'S PHILOSOPHY

An understanding of Heidegger's phenomenology is sought from his major work Being and Time originally written in 1926 in Germany. Heidegger's work in Being and Time is used as the basis for this study because Heidegger seeks to critique the shared experiences of human beings in his analysis of the meaning of Being by uncovering the structures that inform those experiences (Crotty, 1996; Dreyfus, 1987; Guignon, 1998). The distinction between phenomena, the locus of enquiry, and experience, is essential to the process of this study. It is through the experiences of pain that the understandings that people have and which drive the way they know their pain can be understood. It is these understandings that will elucidate the meaning of their Being. The experience is multi-faceted, and primordial, immediate or primary that has not been subjected to rational thought processes or reflection (Crotty, 1996). Crotty (1996) argues that phenomenologists move away from empiricism as a source of knowledge and move toward a broad concept of experience as the source of knowledge. Heidegger moves one step beyond that by recognising that phenomena precede experience as a locus for understanding Being. Heidegger’s work also re-situates the concept of knowing within an ontological framework, specifically within the pre-understandings of the world or the existence of structures prior to any mental interpretation or rational process. In essence Heidegger is saying that much of human behaviour is not a result of conscious choices or reflective awareness.

Heidegger's Being and Time is acknowledged in the translator’s preface, as a difficult book even when read in the original German. Heidegger has used unconventional terminology, as well as an “elaborate vocabulary” (1962, p. 13) of his own, because words that already existed were not able to convey the meaning of his ontological method of philosophy. Spiegleberg (1971)
also refers to the linguistic hurdles of Heidegger’s work and so interpretations and commentaries by Dreyfus (1987), Elliston (1978), Guignon (1998a,b), Kaelin (1988), and Spiegleberg (1971) will primarily contribute to the understanding of Heidegger’s ontology. Heidegger was a pupil of Husserl at Freiburg University and the importance of their relationship in the development of Heidegger’s thinking is demonstrated by the dedication to Husserl in Being and Time (1926/1962), although their work is separated by different underlying philosophical questions of ontology and epistemology.

Heidegger revisits the question of the meaning of Being, ontology, and in doing so places “the Interpretation of time as the possible horizon for any understanding whatsoever of Being” (Heidegger 1962, p. 1). He uses the example of human being within the world, he calls Dasein to explain his methodology of hermeneutic phenomenology, because his question is about the meaning of Being, and this has import solely for human beings. The totality of Heidegger’s account of human experience rests on three axes; Dasein, understanding and temporality (Silverman, 1978, p. 97), while Spiegleberg (1971) identifies the basic themes of Heidegger’s phenomenology as Being, time and history, which are intrinsically connected to each other.

Being and Time (Heidegger, 1926/1962) is used as the basis for the hermeneutic framework because in this work Heidegger undertakes an analysis of the meaning of being. The “meaning” of being is the underlying essential point of this thesis in that it is a way that the being of any entity comes to have any meaning or intelligibility for a person (Guignon, 1998a), and will be explored later in the chapter. This primary, immediate or as Heidegger uses it, “primordial”, meaning is the basis from which pain will
be explored. Primary meaning is the implicit understanding that people possess without being aware of it. It underpins the way people interpret their relationship with the world and its activities. It is the “implicit understandings of the meaning things have without being fully aware of it” (Frede, 1998, p. 57) that is the foundation of a way of knowing that is not cognitive in origin. Heidegger as well as many commentators on his work use the term ‘primordial’ which is used to denote a way of being or understanding that has its genesis in the very first entities of existence that have meaning for human beings prior to any cognitive analysis of those entities. It can be interpreted by using words such as ‘original’, ‘primary’ or ‘immediate’.

The task of phenomenological investigation is to uncover the meaning of being by tracing and articulating the understanding and interpretation that people have based of immediate experiences, and which lead them to deal with the way they live and respond in the world (Frede, 1998).

An important feature in Heidegger’s Being and Time (1926/1962) is the distinction drawn between experience and phenomenon. Such a distinction is a matter of assigning a value to the importance of experience and beyond which the empiricists would value as a source of knowledge. Heidegger’s understanding of phenomena is that phenomena are linked to Being and the elucidation of Being (Pivecëvic, 1975) whereas, experience takes in the concrete aspects of life, and through these the phenomena of being can be understood. This study will use the experiences that form the stories of the pain of the participants and the phenomena will be interpreted in uncovering the meaning of the life of people with pain and who are in the terminal phase of their illness.
Heidegger couches references to Being in ontological vocabulary because of the antithesis of a theoretical structure to his investigation of Being, and in so doing has generated his own vocabulary. Nicholson (1978) makes the point however, that without a theoretical structure we are unable to define Being although our primary understanding of Being is embodied in ontological meanings. It is difficult to find a concrete definition of Being - Being is... What is generally given is what Being means, because there is no framework in which to make defining characteristics. Many of the concepts, terms, and meanings are Heidegger’s invention. However, Heidegger often uses analogy in his explanations, which helps to clarify his meaning. He likens Being to a clearing in a forest where the resulting light shows up other things. The clearing represents openness between a person and their world.

By way of further explanation and because of the unique application of Heidegger’s vocabulary, it is necessary to define the main characteristics, factors and structures of his ontology. These concepts are inter-related and so it is problematic to isolate them as individual aspects, making some repetition necessary. An understanding of the following concepts is fundamental to an appreciation of Heidegger’s ontology and is central to this study:

- **Dasein**
- phenomenology
- hermeneutic, understanding and meaning
- world
- being and Being
- presence, absence
- hermeneutic circle
The above list is not exhaustive of Heideggarian concepts, forming only the basis of an understanding of Heidegger’s philosophy. An elucidation of Heidegger’s meaning of these terms will follow, and other concepts will be defined as they are used within the text.

**Dasein**

*Dasein* is the term Heidegger (1926/1962) uses to describe a person ontologically, that is human existence and is translated as ‘being-there’, meaning a dynamic situation of coping in an unaware state, not always conveyed by translating *Dasein* by the word ‘person’. Dreyfus (1987) describes *Dasein* as the basic structure of human beings. *Dasein* is used to refer to the existence of human beings against a background of shared understandings (Dreyfus, 1991; Guignon, 1998a). Heidegger’s analysis of *Dasein* or the search for the meaning of Being of *Dasein* uncovered the entities that lead to Being and that are only applicable to *Dasein*. The most important factor that distinguishes *Dasein* from other beings is that Being is an issue for it.

Looking at something, understanding and conceiving it, choosing access to it - all these ways of behaving are constitutive for our inquiry, and therefore are modes of Being for those particular entities which we, the inquirer, are ourselves. Thus to work out the question of Being adequately, we must make an entity - the inquirer - transparent in his own Being. This entity which each of us is himself and which includes inquiring as one of the possibilities of its Being, we shall denote by the term "*Dasein*". (Heidegger, 1962, pp. 26-27)
In this way *Dasein* removes the possibility of subject and object. Instead *Dasein's* understanding Being is through temporality - taking hold or letting go of possibilities as they present, and as they are influenced by the past – and is unique to *Dasein*. The temporal horizon or temporality is an important concept to both Heidegger's analysis and also to the exploration of the way people know their pain. Temporality can be explained by Heidegger’s description of human existence as a “happening” (Heidegger, 1962, p. 247). By this Heidegger means that a person and everything that happens to that person and the way a person responds is embedded within an unfolding life story where the past influences the responses in the present and the actions taken towards the future. Guignon (1998b) interprets this to mean that existence is goal directed in a sense although it may not come to awareness. Heidegger (1926/1962) specifically identifies that the future has primacy over the past and the present because action towards the future is informed by the past and can define a present situation that requires some action. The action taken will define the direction that a person will live with in the future (Guignon, 1998b).

Heidegger says the “...essence of *Dasein* lies in its existence...” (1962, p. 67). Existence is not a set of things or properties but rather, possible ways for *Dasein* to be. The conditions for the possibility of *Dasein’s* existence are, moods or attunement, understanding and language (Biemel, 1978; Bleicher, 1980; Elliston, 1978; Kaelin, 1988). These conditions find their expression in *Sorge* (concern, care), a situation of identifying what matters to a person found in the ways a person relates to entities in the world. It is part of Being-in-the-world. When we are relating to other people Heidegger uses the word *Fursorge*, which is normally translated as solicitude to describe ways of being-with. He distinguishes two kinds of solicitude, one
that ‘leaps in’ and takes care away from another, positively, or the other, that ‘leaps ahead’ and gives care back, authentically.

Moods, understanding and language are existentiales, that is, they are related to the primacy of existence. They provide the means by which Dasein comes to be interpreted and through which the world is also interpreted. Heidegger contends that “Dasein’s openness to the world is constituted existentially by the attunement of a state-of-mind” (1962, p. 176). A person’s continuum with the world is interpreted by moods and is reflected by moods, being always in a mood, and so always with a certain understanding. They are primary conditions of existence and are inter-related.

Dasein is thrown into a world that already exists in terms of culture, history, language and understandings. Through interaction with this world, Dasein has the ability to make individual understandings of a situation. This interaction is rooted in the primordial or primary meaning or connections Dasein already has with the world and is driven by the desire to be authentic, that is, to be oneself. This drive to be oneself can be interrupted by interactions with the ‘they’ or ‘das man’- other people and technology, and then Dasein behaves inauthentically. Schatzki, (1992) argues that interaction with others identifies the intrinsically social nature of being and that it defines the common and accepted ways of behaving and living. The defining issues for Dasein are ‘sorge’ or those of concern, and the horizon for concern and authenticity are found in Dasein’s temporality, a temporality in which the past influences the present which identifies possibilities for the future.
Heidegger’s method for uncovering the meaning of Being, is a circular one, beginning with the entity to which the ontological question is addressed, Dasein, and ending with the meaning of Being of Dasein. Dasein is the only being that is able to question the meaning of its Being and in the process uncovers entities that lead to Being.

**HEIDEGGER’S PHENOMENOLOGY**

Heidegger explains his use of phenomenology as “a methodological conception” (1962, p. 50), which characterises the ‘how’ rather than the ‘what’ of the subject matter of philosophical research. It is a means of uncovering what has been hidden and a way of going “back to the things themselves” (1962, p. 58), in the quest to understand the meaning of Being. Using this as a method in his existential analytic, *Being and Time* (1962). Heidegger makes clear the connection between Being and time as the horizon for understanding (Kaelin, 1988).

Heidegger rejected the then current concept of the subject/object way of people relating to each other and their environment. Dreyfus (1987) makes the point that awareness and consciousness do not have a role in Heidegger’s phenomenology. In its place is an understanding of the world that is founded within the primary understanding that comes from immediately being born into and becoming part of a shared culture, language and way of life. The resulting understanding does not need to be filtered cognitively but becomes a transparent way of coping with the world. The entities encountered in this way Heidegger refers to as ready-to-hand. It is important to make the point at this stage that Heidegger is referring to a way of being in everyday life although, this can be interrupted when something goes wrong thus creating the possibilities of either examining the context within our lives, or seeing entities as contextless or within a subject-
object relationship (Guignon, 1998a). This is an important component of exploring the phenomenon and experience of pain.

Dreyfus (1987) comments on Ryle’s distinction between the traditional ‘knowing-that’ approach to phenomenology and Heidegger’s unique ‘knowing-how’, which exists prior to any mental state and suggests that the two states exist. Heidegger (1926/1962) uses the example of a carpenter and hammering to illustrate this transparent knowing-how. He argues that a person hammering with hammer and nails (tools that are ready-to-hand) is able to continue the act of hammering while engaging in other activities like talking (transparent way of coping). The hammerer does not need to engage mentally in what is happening with the hammer. “The more we seize hold of it and use it, the more primordial (transparent and primary) does our relationship to it become” (Heidegger 1962, p. 98). This unique conception of phenomenology is further defined when Heidegger analyses its two components ‘phenomenon’ and ‘logos’.

**PHENOMENON**

Phenomenon is “that which shows itself in itself, the manifest” (Heidegger, 1962, p. 51). These phenomena are not always overt but can be hidden or have a misleading appearance. The phenomenological conception of phenomena is not descriptive, it calls for a method as Spiegelberg argues, that “makes us see what is normally hidden and forgotten” (1971, p. 321). The phenomena of Heidegger’s phenomenology are those entities that are normally hidden and through which we gain an understanding of the meaning of Being. Importantly the phenomena are not descriptions of shared human experiences but what those experiences are derived from, the hidden, unnamed “pre-understandings” that are always there (Crotty, 1998;

Gelven (1978) cites the historical use of masks as a means of revealing our true selves. Heidegger (1926/1962) explains this paradox by using the analogy of disease symptoms. Symptoms show themselves but indicate something which does not show itself - the disease. In uncovering the disease we must approach the symptoms critically and not just use them to describe a disease. In the same way we use entities in a critical way to uncover Being. These entities may be ontic or ontological, the former as they relate to the more concrete entities or structures of existence, and the latter that are primarily concerned with Being. It is only through existence and the masks that present to us, that we are able to uncover Being or the final reality as it exists for a person, made individual by that person’s interaction with their environment, and their life story or horizon of temporality.

**LOGOS**

The logos as Heidegger defines it is a method or science of uncovering what is normally hidden as it relates to the fundamental intention of explicating Being. Speigleberg (1971) makes the important observation that it not only makes us see what is normally concealed, but advances the notion that this unhidden Being as disclosed, is truth. Truth is then the ‘what’ that has been discovered through logos. The logical conclusion is that truth is Being and Heidegger alludes to this by saying that “...Being does go together with truth...” (1962, p. 256). The underlying presumption is that truth is often hidden in the shared context in which people live.
Heidegger describes phenomenology as a method of research based on a philosophy of Being or ontology, "... the expression 'phenomenology' signifies primarily a methodological conception" (1962, p. 50). It does not characterise the 'what' of the objects of philosophical research as subject matter, but rather the how of that research. The meaning a phenomenological study has, lies in its interpretation or hermeneutic.

**HERMENEUTICS, UNDERSTANDING, MEANING**

Historically, the word hermeneutic has been used to describe the "theory and practice of interpretation" (Thompson, 1990, p. 229). It was regarded as a discipline in itself particularly in the field of theology. In this sense it refers to biblical exegesis although its origins can be traced back to ancient Greece, derived from Hermes. (Bleicher, 1980; Thompson, 1990). Its etymology is from the Greek verb *hermeneuein* and means 'to interpret' which forms the noun *hermeneia*, 'interpretation'. Thompson (1990) traces the history and divergence of contemporary hermeneutics with the current diverse discourse which rests on many varied assumptions. This discussion will focus on Heideggerian hermeneutics.

Heidegger uses the word hermeneutics in a number of unique ways, all of which are grounded in interpretation. He describes the use of hermeneutics, as; an expression of the meaning of Being; the conditions which ground an ontological study of entities other than *Dasein*; and as an "analytic of the existentiality of existence" (1962, p. 62). Within these classifications Heidegger has adopted the ancient discipline of hermeneutics for uniting the elements of his philosophy - understanding, ontology and phenomenology. Heidegger states that hermeneutics applies to all understanding and interpretation.
Any interpretation which is to contribute understanding, must already have understood what is to be interpreted. This is a fact that has always been remarked even if only in the area of derivative ways of understanding and interpretation…. (1962, p. 194)

Understanding is essential to *Dasein*, because “without understanding there can be no *Dasein*” (Walters, 1992, p. 39). Heidegger says that understanding is projecting in terms of possibilities, “understanding has in itself the existential structure which we call ‘projection’… *Dasein* has always understood itself … in terms of possibilities” (1962, p. 185). This statement is at the core of interpreting Heidegger’s fundamental philosophy. The term ‘projecting possibilities’ does not mean predicting a future direction or planning a way forward, rather, Heidegger’s sense of ‘possibilities’ refers to alternative ways of being or roles to act out against a common background or framework. It is this common expectation of how things should behave or work that makes them do so and thus ‘projects’ a way of behaving or role onto entities; an understanding of how things are. Haugeland reasons that, “It is only in virtue of *Dasein’s* concrete being-amidst – selves actively dealing with things and taking care of business – that those things have roles” (1992, p. 38).

It is the disclosure and articulation of this understanding that provides meaning. If Being remains not understood and therefore undisclosed, “it is meaningless” (Heidegger, 1962, p. 193). Therefore, integrally related to the process of interpretation are the concepts of understanding and meaning. Taylor (1987) identifies the act of making clear or making sense of a ‘text’ or subject the goal of interpretation, a process more akin to the separation of object and subject. As Heidegger intended, though, hermeneutics is a way of discovering entities and the Being of *Dasein*, “when they have come to be
understood - we say that they have meaning. But that which is understood, ...is not the meaning but the entity, or alternatively, Being” (1962, pp. 192-193). The important and unique aspect of his theme is that understanding is a self-projection of a person into possibilities, “*Dasein* always understands itself in terms of its existence - in terms of a possibility of itself” (Heidegger, 1962, p. 93). Understanding, meaning and interpretation become important links in uncovering the ontology of knowing because of their relationship with the temporality of Being, as will be discussed later in the chapter.

As a person comes to understand, choices can be made which may be authentic or inauthentic. The ability to make choices in relation to authenticity and understanding is a subject of debate. Olafson (1987) supports the role of choice within the range of understanding possibilities as individuals and in contrast, Schatzki, (1992) argues against choice being a factor within the ordinary way of understanding possibilities. In fact Heidegger, (1962, p. 312) identifies that choices exist although against a background of commonly accepted possibilities. A person who is authentic is being him or herself and one who misinterprets him or herself, or interprets inappropriately, is being inauthentic. These are important concepts to Heidegger’s analysis and to this study. It is essential to point out that contrary to conventional use, these words in a Heideggarian sense, do not connote an ethical perspective or a sense of superiority or weakness (Heidegger, 1926/1962). Heidegger identifies imperceptible anxiety (Angst) as the awareness of authenticity as it is a result of inappropriate disclosure of understanding. Anxiety is the driving force towards authentic being. Working towards authenticity is the more usual state of being rather than always being authentic (Ree, 1998). Inauthenticity is usually borne of acceptance of the interpretations at a cognitive level, of a whole society and
that governs thoughts and behaviours or acceptance of “popular conceptions” that Heidegger (1962, p. 185) warns should be tested against other more primary beliefs/values. Heidegger (1926/1962) argues that it is the anxiety of coming to terms with our finite being as we approach death that is the focal point in a person moving towards authenticity.

Heidegger makes clear that understanding is not derived from knowledge, but is a primary or universal structure of human existence or a basic mode of Dasein’s Being. It is the disclosure of the meaning of an entity. Hermeneutics in a Heideggarian sense, connects three concepts fundamental to ontology; understanding, meaning and being. One does not exist without the other. All three are grounded in Being.

Human understanding is a circular process “by which what is given as a pre-ontological comprehension, and therefore as only implicit, gets laid out into a system of explicitly understood ontological connections” (Kaelin, 1988, p. 106). The hermeneutic circle is the primary structure of Heidegger’s hermeneutic but will be discussed later in the chapter. This division is arbitrary which makes separation difficult and may dispose the hermeneutic to misinterpretation.

**The World**

Heidegger’s phenomenological method uncovers Being through its entities as they exist in the connection between a person and their world. They are found in the everydayness of living in the world, that is, as a hermeneutic that reveals the immediate understanding of the world which “informs all our day to day interpretations” (Crotty, 1996, p. 84). In our everydayness, things present to us as a presence which shapes the world we live in. Our world is that in which we find ourselves when we are born into it (thrown),
with its culture, language, customs; borne of the amalgamation of past and present. The possibilities of this union for the future stem from a person’s way of knowing this world and their oneness with it. To emphasise the importance of the world, Heidegger uses hyphenation with much of his vocabulary to demonstrate a person’s connection to the world and their relationship with it. There is no distance between a person and their world; they are part of it as the world is part of the person. The immediate world a person finds himself in, as opposed to the natural world, is a part of the ontological existence of being-in-the-world. Kaelin (1988) explains that the world of being-in is created by a person’s unique self-projection within their surroundings, making it an active process of existence.

**being**

Heidegger makes a distinction between Being (Sein) and being (seiendes) which produces a further complexity. As there is only one word in English for ‘being’, translators have made the distinction by use of upper case and lower case ‘b’. Essentially Being is the state of existence for all beings, person, animal, tree, wood. All beings have entities, which when discovered or encountered, contribute to the meaning of Being. Heidegger (1926/1962) uses the being of Dasein as an example to demonstrate his method for uncovering the meaning of Being. In so doing he uncovers entities of Dasein.

**BEING**

Being can be a difficult philosophical concept to grasp because it is intangible, it has no space, no time, no boundaries with which to enclose it. It is not an entity. According to Heidegger (1956/1958) philosophical concepts must be grasped, and this is possible only if a person is attuned or disposed to grasping the notion. Being is a concept that Heidegger uses to
explain existence in an immediate sense, prior to intellectual activity, but which is grounded, temporally, in history, influencing the present and anticipating the future. It is the way people and things, and people and people, relate within the world. It demonstrates the openness between people and their world and hence a mutual sharing of things encountered, not as sometimes interpreted mutual meanings of Being. Meanings come to be individualised through understanding interpretation and the drive to be authentic although they have a basis in shared practices, culture, and everyday experiences.

In support of his resurrection of the question of the meaning of Being, Heidegger (1926/1962) identifies three presuppositions of Being essential to his project:

- Being is the most universal concept “an understanding of Being is already included in conceiving anything which one apprehends as an entity” (Heidegger, 1962, p. 22);

- the concept of Being is indefinable, because of its universality. It does not have the character of an entity, it “cannot be derived from higher concepts by definition” (Heidegger, 1962, p. 23); and

- the concept of Being is self-evident as we already live in an understanding of Being (Heidegger, 1962, p. 23).

**Presence and Absence**

An interpretation of Being within the paradox of presence in absence is offered here, following the work of Nicholson (1978) and Olafson (1995). This paradox is an essential part of Heidegger’s philosophy, but one that has not previously been well developed (Benner, 1985; 1984; Koch, 1995; Leonard, 1989; Walters, 1995). Heidegger, in his analysis or ‘destruction’
(breaking up) of ontology identifies the term ‘presence’ as the ontologico-
Temporal understanding of Being (1962, p. 47). As he began his
explorations, he returned to the Greek foundations of ontology, where the
Greek word ὑπάρξεια is used to signify Being and which translates as
‘presence’. Heidegger offers two interpretations of presence, which
Nicholson (1978) summarises as; the temporal meaning, Being as presence
refers to existence emerging into presence, and presence-at-hand, or what is
before one or presents itself.

These two forms of presence are important because they identify a pre-
reflexive way of coming to know something, although they do not articulate
the past and future which form the horizon for Being. It is only in the
recognition that Heidegger’s presence “is informed essentially by absence”
(Nicholson, 1978, p. 192) that the temporality of Being is reinstated.
Heidegger himself identifies the central relationship between presence,
temporality and absence within the structure of Being, “… for time itself
passes away. But by passing away constantly, time remains as time. To
remain means: not to disappear, thus, to presence” (1975, p. 3).

Olafson (1995) offers an application of Heidegger’s notion of presence to a
reading of ‘what is a human being’. Presence signifies the unity of a person
with their world, which may be interpreted as Heidegger’s ‘Being’. It is the
world being-there for us prior to any mental mediation. Olafson replaces
object/subject reductions - perception - with states of affairs which he
demonstrates renders the whole notion of perceiving objects as superfluous.
He argues “that states of affairs must not be taken out of the world … that
states of affairs are precisely the form of the world itself” (1995, p. 66). He
identifies that presence is intimately related to temporality and the openness
of Being to the world whereby mutual interactions between world and
person are in constant play. Based on this understanding, Olafson (1995)
follows Heidegger by proposing that presence is something in the world that
manifests itself to another entity. Nicholson goes as far as saying presence
is Being by quoting Heidegger “this very presence, its innermost core, lies
deep within the earliest names for Being” (1978, p. 180).

Presence is the fact of encountering the world and absence is a modality of
presence dependent on a revision of the meaning of memory, imagination
and temporal distinctions. In other words presence is the entity that is
presented to us and absence is how the entity is encountered (Olafson, 1995,
p. 91) or disclosed to us. This conception again brings to the fore the
analogy of the mask. It is what is absent, particularly to perception, that is
present to us, ontologically, as a person in the world. Nicholson supports
this view and endeavours to clarify the concept of presence in absence and
its relation to Being by suggesting that,

The word Being is used ... to designate that act
whereby something reaches out from an obscure
zone of absence and comes into presence. Because
it has come into presence it can appear to us. It is
not our apprehension which has lent it presence;
presence precedes our apprehension. ...Things
distant from us in space and time do not lack Being
because they do not lack presence. ... Their action at
a distance occurs throughout he continuum of the
universe itself, history and the continuum of
language (1978, p. 192)

The concept of presence is important to the later development of knowing as
ontology, presented later in the chapter.
HERMENEUTIC CIRCLE

As mentioned previously, Heidegger’s phenomenology is one of method not of substance. Heidegger has extended the traditional application of the hermeneutic circle to the ontological understanding of human existence. It begins with a question about the meaning of Being and has an entry point at the union between human existence and the world. This union is the basis from which the analysis is pursued in seeking understanding of the primary (primordial) entities that exist before giving off shared interpretations and understandings. Being is always there but it cannot have meaning unless it is of concern to human beings. Pursuing the pre-understandings that pre-empt shared interpretations and understanding forms a circle of understanding or hermeneutic circle (Hoy, 1998). It is by travelling the circle that Heidegger comes to an understanding of the meaning of Being. The initial question contains a structure inclusive of: that which is questioned - the entity; that which is asked about - its being; and that which is learned by the asking - the meaning of its Being (Heidegger, 1926/1962). The structure necessitates an implicit supposition about what is to be found. Kaelin (1988) describes the structure as an implicit pre-understanding and the understanding we end with is explicit, the fore-structure of understanding.

The pre-understanding that Kaelin refers to is primary to any other way of existence and begins the circular process of understanding. It underpins the average everyday activities of a person’s being, and which will be argued, is a way of knowing ontologically. By following the circle, the ontic and ontological dimensions that contribute to an understanding of the meaning of Being will need to be uncovered. The circle involves a reversal from the ontic dimensions found within the daily life of each person, back towards
the ontological structure of their Being. This concept is presented diagrammatically in figure 2.

Figure 2: Diagrammatic Interpretation of Heidegger’s Hermeneutic Circle

PHILOSOPHY AND NURSING
Ways of knowing cancer pain as the thesis of this research study are framed within the philosophy of Heidegger. Thus, it presumes a role for philosophy in nursing, as does much of the contemporary nursing literature. Ironically, philosophy is rarely taught as part of undergraduate or postgraduate nursing education (Royal College of Nursing, Australia, 1999) thus ignoring the role it plays in much of current nursing research. Nurses have learnt about philosophy heuristically or via other disciplines and according to Crotty (1996), have applied it to nursing, creating distortions to the original philosophical meanings. Diekelmann (1989) and Diekelmann and Rather (1993) initiated debate of the role of philosophy in nursing education, which
is beginning to attract more attention in nursing research related to practice, but continues to lack any universal strength or conviction by the profession in terms of education. Most of the philosophy education undertaken by nurses remains outside the nursing education curriculum in Australia, or is very circumscribed (Royal College of Nursing, Australia, 1999).

One of the issues raised by Crotty that has implications for this study is that nurses have created a “new phenomenology” (1996, p. 3) without objectivity or critique, which focuses on the purely subjective nature of the objects or people within the study. There are a number of issues around the ‘subjective’ aspects found within Heideggarian phenomenology, notwithstanding Heidegger’s (1926/62) own description of two kinds of subjectivity, which adds confusion to the interpretation of Heidegger’s work. Crotty’s (1996, 1997) critique has not gone without a response from the profession (Darbyshire, Diekelmann & Diekelmann, 1998), although this response focusses on only part of Heidegger’s critique, which was very wide ranging. These issues are discussed in more detail below and another aspect of Crotty’s critique, the use of subjectivity, will be addressed.

Nursing literature (Geanellos, 1997; Sarter, 1987; Silva, 1977; Walker, 1971) has continued the debate about philosophy and nursing for three decades and is still questioning the relationship between them (Geanellos, 1997). Much of the discussion is segregated by attempts to identify the philosophical roots of nursing theory, education and research without any unification. Geneallos (1997) however, does suggest that a common dialectic is possible and Silva offers the most realistic interpretation of the relationship between nursing and philosophy. Importantly, she reinforces philosophy as the beginning of all science which continues to play a role in understanding, revealing, and questioning issues related to human existence and knowledge, “before and after the scientist has done his job” (1977, p.
60). Philosophy does not create knowledge, it allows knowledge to be understood or revealed (Heidegger, 1926/1962). Silva (1977) also makes the point that all nursing research and theory is derived from philosophy or its branches of logic, epistemology, metaphysics and ethics. She does not include ontology, although Heidegger (1926/1962) argues philosophy is grounded in ontology.

One of the roles of philosophy is to search out meanings. Unseen implications, unexamined assumptions, and unobserved meanings are the grist for all philosophers (Christian, 1977). Christian invites all to wonder and to question always even the most accepted beliefs of society. All these reasons are resonant with nursing ideals which suggest that philosophy should have a much greater and more formal role in nursing education and development. It is the challenge that philosophy has set that embraces the re-location of knowing within ontology. There is no value in such an undertaking unless the underlying premise, that philosophy is worthwhile to nursing, is acknowledged, as epistemological and ontological standings are in essence philosophical.

**PHENOMENOLOGY - ITS RELEVANCE FOR NURSING**

Heidegger's phenomenology has much relevance for nursing, and is increasingly used as a framework for nursing studies. Kestenbaum identified that phenomenology has long served as the "general rubric for attempts to look at the world through the eyes of the patient" (1982, p.20). The most recent and notable nursing proponent of Heidegger is Benner (1984; 1985; 1991; 1994), although Watson (1979) and Paterson and Zderad (1976) also identified a sound relationship between nursing and phenomenology. Diekelmann (1989; 1992; 1993), also a strong proponent of Heideggarian phenomenology, has focussed on the experiences of students and educators
in nursing education. The foundations set by these scholars has continued and evidenced by the number of phenomenologically based research studies, phenomenology is gaining strength in nursing. In looking for an alternative to positivist science, nurses wanted a methodology that better reflected their belief about the holistic nature of the person and the existence of multiple realities. Heidegger fulfilled both these criteria because his philosophy rejected reductionism in favour of a unified person/world, and he challenged the correspondence theory of truth saying “truth is relative to Dasein’s Being” (1962, p. 270). Nurses have largely focused on these aspects, at times to the relative neglect of other equally important and connected notions of understanding and meaning within a Heideggarian perspective. Understanding and meaning have significance for nursing not only within commonly accepted epistemological interpretations but also within Heidegger’s interpretation within an ontological perspective.

THE AUSTRALIAN CONTEXT

Australian nurses have accepted the qualitative paradigm as a means of expressing the work they do, although this acceptance has been questioned by Holmes (1996) who argues that it is more of a resistance to engagement with the positivist traditions. Australian nurses, in embracing qualitative methods have explained and analysed the relevance of Heideggarian phenomenology to nursing (Crotty, 1996; Koch, 1996; Lumby, 1991; Parker, 1991; Walters, 1995;), as well as the value of phenomenology to nursing as a method within an alternative paradigm to positivism (Bartjes, 1991; Lawler, 1991; Taylor, 1994; Wilkes, 1991). Lumby’s interpretation and application serves to demonstrate this by acknowledging that nurses identify with Heidegger’s multidimensional view of a person and the freedom of being-in-the-world. Nurses work towards enabling people to choose an “authentic” alternative and even “to remove themselves to a
context which provides greater possibilities” (1991, p. 480). She goes onto explain that illness must be studied within the context of existence for a person, not just as a “snapshot” of their life.

One type of Heideggarian application to nursing, is the misapprehension that Heideggarian phenomenology supports a purely subjective or humanistic view of the person, such that it borders on solipsism (Jasper 1994; Nelms 1996; Rose, Beebe & Parker 1995). This development will be discussed in relation to Crotty’s critique (1996) although it can be argued that many nurses in Australia, have identified a commitment to scholarship (Koch, 1996; Lawler 1991; Parker, 1992; Taylor, 1994; Walters, 1992) and the application of rigour to qualitative research (Koch, 1994).

CRITIQUING PHENOMENOLOGY

Many nurses do not always identify a particular philosophy that grounds their practice, although some nurses have adopted a phenomenological method in their research, a situation that has not been without problems. Difficulties include the heuristic pattern of development and lack of a critique of phenomenology, Heideggarian phenomenology in particular. Essentially, it has been left to nurses to find their own way as part of an evolving process of qualitative nursing research.

Crotty has made a distinctive contribution to this process by publishing a critique of ‘phenomenology and nursing research’. He reviewed a number of phenomenological studies from North America and identified the misinformed notions of phenomenology on which these studies were based. His analysis includes the work of Benner as well as published studies of thirty other nurse researchers. Using his experience and knowledge of
phenomenology to examine their work against the phenomenology of Husserl and Heidegger, he identified in the "new" phenomenology an absence of "objectivity and critique" (1996, p. 3).

Crotty suggests that many researchers look only at the subjective experiences - feelings, attitudes and emotions of people and do not uncover the phenomena as lived pre-reflectively. Crotty (1996) demonstrates this by identifying the researchers' use of subjective everyday experiences without recourse to the phenomenon they wish to uncover. These experiences are often identified with the intention that they pertain to the individual, however, they are then analysed as shared experiences or collective themes, contrary to Heidegger who argues "Dasein has in each case mineness" (p. 68) which is related to being authentic or inauthentic as the case may be; and "Dasein's Being is distinctive in that it implies the possibility and the necessity of the most radical kind of individuation" (p. 62). Individuation according to Heidegger, is different to the subjective humanism as interpreted by many researchers. Heidegger's goal is to explore the meaning of Being and he is concerned with human beings as a manifestation of Being, as Crotty (1996) points out, not to explore the meanings of everyday practices within the "full dimensions" (p. 81) of humanism. Heidegger's phenomenology is subjective in that its point of departure is the person, but it is concerned with the Being of person, including, Being-in-the-world. However, Crotty's interpretation does not completely uncover the complexity within Heidegger's work, especially that related to the subjective nature of Dasein.

Heidegger's condemnation of the subjectivity of Descartes can be a confusing aspect of his sense of individuation. He saw the human will as an extension of that subjectivity which is counter to his philosophy of Being
(Spiegleberg, 1971). Heidegger uses the word ‘subjective’ in two distinct ways: subjectivity relative to the self and being-in-the-world; and subjective as a condemnation as others might use relative to the self _qua_ self. Whether the subjectivity of many nurse researchers parallels the subjectivity that Heidegger condemned, is not always clear because of the alternate meanings of ‘subjective’. Perhaps one explanation offered for the humanistic approach taken by nurses in their Heideggarian adaptation, is their desire to counter Descartes’ dualism of the person and the context in which they live.

Another essential dimension surrounding the debate about the dichotomy of the individual and Heidegger’s collective of _Dasein_ is the role that Heidegger places on the ‘self’ in unravelling the notion of Being. Heidegger, (1926/1962) as in the rest of his work, does not clearly articulate the relationship of ‘self’ and the broader concept of _Dasein_ which has created confusion about this aspect of his work. He does however, thread the theme of self and the individual throughout _Being and Time_, a thread that Schatzki (1992) explores in detail. Essentially Schatzki argues for the relationship of individual people with _Dasein_ because: Heidegger insists on the use of personal pronouns when referring to _Dasein_; the possibility of authenticity as a mode of existence; Heidegger’s use of expressions such as _Dasein_ as a “subject”, and “the individual _Dasein_” (for instance, Heidegger, 1962, pp. 219, 221); Heidegger has developed an argument for _Dasein_ encountering entities solely as a feature of being an individual person; and his concept of “metaphysical isolation” that refers to the “individual as a clearing of being in which things can show themselves” (Schatzki, 1992, p. 84), an interpretation that is supported by Heidegger’s admission that “each _Dasein_ has its own transendence” (Schatzki, 1992, p. 84).

The distinction between individual and the collective is an argument that is important for nurses because their work is inherently focussed on the ‘self”
of the person that they are caring for. Heidegger refers to the essential role of ‘self’ in understanding the meaning of Being, “Dasein understands itself in terms of that with which it is customarily concerned. One is what one does” (Heidegger, 1962, p. 283). Young interprets this as the “appearance of the self is the self in itself” (1997, p. 57) in its average everydayness. This is a realistic interpretation given that Heidegger very clearly points out that “our essence lies in existence” (1962, p. 67). This interpretation relates to Heidegger’s hermeneutic circle – determining the ontic everydayness as a process to understand the ontological dimensions of the meaning of Being.

In Descartes’ cogito ergo sum the person is portrayed as a subject of their consciousness, and nurses are attempting to interpret a person in their wholeness (Koch, 1996; Lawler, 1991; Parker, 1991; 1992; Taylor 1994; Walters, 1992). Heidegger’s portrayal of a person at one with their world as a way of existing is different to exploring feelings, attitudes and everyday practices as a way of existing ontologically. Feelings, attitudes and everyday practices are ontic and as such are a legitimate means of travelling the hermeneutic circle towards uncovering Being. Often though, the reversal back to the ontological starting point, is not made.

Hoffman, (1993) argues for the place of the individual as having a legitimate foundation in Heidegger’s philosophy. He contends that Heidegger aimed, in Being and Time, to question and to overcome the subjectivist tradition of modern philosophy. However, he goes onto argue that in Division 11 of Being and Time, “Heidegger reveals himself as an heir to that tradition and to its model of the human self” (Hoffman, 1993, p. 195). Heidegger’s exploration of moving towards death becomes the foundation that provides the totality and “mineness” of a person’s existence. Hoffman’s contention that Heidegger supported the modern trend of
humanism is not altogether well founded because Heidegger identified the individual as one part of the relationship between Being, *Dasein*, the world and the self, whereas Humanism took the subjectivity of the self as the sole means of re-interpreting existence (Hoffman, 1993).

Identifying the subjectivity inherent in some Heideggerian applications has precluded discussion of an area in Being and Time (Heidegger, 1926/1962) that is important although potentially confusing. There has been such a backlash against the use of subjective or individualised content in applying Heidegger’s work that an important point has been lost in the ensuing works. Heidegger is primarily concerned with the meaning of Being and how that is found within shared meanings and understandings of Dasein. Dasein of course is a generic entity or a “general way of being” (Dreyfus, 1987, p. 263) and one that does not generally lend itself to an understanding of the individual. However, Heidegger in his analysis (1926/1962) discusses both the individual and the general way of being. Dreyfus (1987, 1991) is clear in his interpretation of Heidegger, that Heidegger begins with the general sense and moves to the individual – always on a shared background. He does this most notably in Division two of Being and Time that discusses authenticity where a person no longer responds to the general situation but rather to the unique situation (Heidegger, 1926/1962). Although authenticity is set against a background of shared practices and meaning, it allows for flexibility and the development of the individual (Dreyfus, 1987).

A number of authors discuss the relationship of the individual to the generic human being, Dasein, and to Heidegger’s analysis. (Spiegleberg, 1971; Elliston, 1978; Kaelin, 1988; Haugeland, 1992; Schatzki, 1992; Olafson, 1995; Ree, 1998; Guignon, 1998b). Much of the discussion is complex and
detailed but essentially there is consensus that Heidegger has not ignored the place of the individual human being in his analysis. The individual is not just characterised within an inauthentic mode but is an “ability-to-be” channelled into “concrete possibilities” (Heidegger, 1962, p. 236). Ree makes the important distinction that “individuality as being-in-the-world has nothing to do with the individualism of the they-self” (1998, p. 28). Heidegger (1926/1962) uses the word solipsism to define the subjectivity of self qua self although separates this “solipsism” from subjectivity/individuation in an ontological sense. Ree (1998) in interpreting Heidegger synthesises this separation by describing two kinds of solipsism, existential solipsism and classical solipsism. Haugeland argues that the individual is a particular “case of” Dasein and is “nothing more than the peculiar integration and adjustment of various ‘public’ ways of life as idiosyncratically adopted and lived by one person” (1992, p. 36). Schatzki argues in more depth for the place of the individual in Heidegger’s philosophy of Dasein and identifies five reasons to support this view. He precisely states that,

It is important to stress that Dasein refers to individual people because ... failing to grasp it makes understanding of Heidegger’s view on the socio-historical nature of human existence and understanding impossible (1992, p. 82).

The concept of the individual within Heidegger’s work is an important concept because of the inappropriate prominence it has gained over the more primary Heideggarian concepts discussed above, and the resulting neglect of it as a part of Heidegger’s overall philosophy. More significantly the idea of the individual is an important one in nursing because the primacy
of nursing is about the holistic care of the individual. That is not to say that the ontological and unifying basis of Heidegger’s work is not also of primary importance. The challenge then is to adopt a rigorous application of Heidegger’s work with the underlying philosophy of nursing.

HEIDEGGER’S NAZISM
Nursing studies based on Heideggarian phenomenology are increasing, as nurses identify with aspects of his philosophy. However, Heidegger has not been completely accepted as a philosopher suitable for application to nursing, with criticisms of his nazi background becoming more vocal (Holmes, 1995; Crotty, 1996). Considering nazism is diametrical to the ideals of nursing, and objections of its application to nursing have been raised, and thereby raising ethical concerns, it is important to make some brief mention of Heidegger’s nazi involvement. As Holmes (1995) points out there has developed quite a body of literature that discusses, examines and analyses Heidegger’s nazism. Some are apologists for his actions, supporting the notion that he was attempting to appease Hitler and support changes to a severely declining social and economic structure of Germany. Others acknowledge incongruence between the man as nazi and his philosophies. Some others reject his philosophy because they reject his nazism and see that one is a product of the other, and others engage in “useless moralising” (Sluga, 1993, p. 4) or reduce the argument to one of psychology and therefore denying the context surrounding Heidegger’s involvement. It is difficult to argue for a person when that person openly supports, as Heidegger did, the evil excesses of the nazis. Sluga (1993) argues though, that it is possible to separate the man from his philosophy. However, this perspective is contrary to Heidegger’s own philosophy and teachings of Being and his rejection of the theoretical and the practical
(Young, 1997). Reading the nursing literature, it appears that nurses identify with the philosophy and not with the man, of whom many do not have any depth of knowledge.

This thesis does not represent an apology for Heidegger's nazism, rather it accepts that Heidegger's involvement with nazism was real although represented only a short time in his life whereas his philosophy was an ongoing and evolving process that consumed most of his life. As Young points out simplistic reasoning does not fit with the notion that human beings are "complex, richly inconsistent creatures" (1997, p. 5). Young (1997) clearly points to evidence that Heidegger's philosophy was not grounded in nazism nor was it a product of nazism. This thesis utilised Heidegger's work and has adopted Heidegger's philosophy as a framework because of his explication of *Dasein* and the ontological structure of knowing that he offers. As Spiegelberg (1971) attests, it is difficult to know why Heidegger chose nazism as he has never explained this involvement and confusion and debate continue to surround Heidegger's nazism as a result (Guignon, 1998a). Application of his philosophy recognises the validity of the philosophy not the temporary politics of its author.

Heidegger's philosophy of the meaning of Being is complex and often confusing because of his expression, language and the subject matter he deals with. However, despite the many difficulties, including the ethical connotations surrounding his nazis involvement, Heidegger has much to offer nursing in the examination of practice and contribution to nursing knowledge. An application of Heideggarian ontology to the concept of knowing both extends nursing knowledge and contributes to nursing practice while providing a crucial perspective from which to inform this study.

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Chapter 3 – Phenomenology, Ontology and Knowing
KNOWING: A RE-LOCATION
The location of knowing within ontology is essential to this thesis and so it will be argued from a Heideggarian perspective how this will be achieved and the role such a shift already has in nursing. Heidegger demonstrates that knowing has an ontological character that is of primary importance in his phenomenology. He writes, "it would still be our first task to show that knowing has the phenomenal character of a Being which is in and of the world" (1962, p. 87). From a Heideggarian position, knowing becomes an essential characteristic of Being and Being-in-the-world distinct from the knowledge that is part of cognitive processes. Knowing becomes a way of understanding in an ontological sense that is always available and informs the day to day activities of people. Hall argues that we do not normally attend to the knowing that underlies the everyday activities in which we are involved through that knowing – it is "...transparent and invisible" (1998, p. 132). The knowing that accompanies activities provides the background "...without which things and others could not be encountered, namely, the world" (Hall, 1998, p. 133).

KNOWING AND KNOWLEDGE
Knowing is often used interchangeably with knowledge, and so knowing has come to be regarded as knowledge, so much so that it is difficult to find definitions of, or distinctions between the two. It could be argued that there is no need for separation which may be regarded as arbitrary and of no real value. It is the intention in this thesis to use the term 'knowing' as separate from intellectual or cognitive knowledge, and it is argued that a type of knowing exists that is not dependent on mental processes. This thesis challenges the concept of knowing that exists solely within the cognitive realm and places knowing within the realm of ontology, based on Heidegger’s philosophy. The value of this view is that knowing is seen as a
way of Being and therefore not constitutive of mind-body, subject-object reductions. Knowing is placed within the primary structure of human beings and therefore informs their everyday activities.

**Knowledge as a Cognitive Event**

Knowing and knowledge are generally regarded as processes that primarily involve cognitive awareness, perception and assimilation in the process of acquiring, transmitting, refining and ordering what we know. The branch of philosophy that is concerned with the process of knowledge is epistemology. Schultz and Meleis offer a clear definition of epistemology and its role in nursing:

> Epistemology is the study of what human beings know, how they come to know what they think they know and what the criteria are for knowledge claims. Nursing epistemology is the study of knowledge shared among the members of the discipline, the patterns of knowing and knowledge that develops from them, and the criteria for accepting knowledge claims. (1988, p. 217)

Much discussion has taken place in the literature over the role and definition of knowledge in nursing and nursing knowledge (Carper, 1978; Dickoff & James, 1968; 1988; Dickoff, James & Weidenbach, 1968; Hinshaw, 1989; Jacobs-Kramer & Chinn, 1988; Tinkle & Beaton, 1983; Munhall, 1993). It is not necessary to examine their claims except to say that the common link is the acceptance of knowing as fundamentally a process of the mind. The literature discusses nursing knowledge in relation to theory and practice and the ensuing complexities, although Dickoff and James (1988) venture into the debate with reference to the distinctions of ‘knowing-how’ and
‘knowing-that’, derived primarily from the work of Polyani (1962). Polyani also recognised a more personal way of knowing the world which is the reason for different interpretations in nursing.

Polyani’s work has been important to nursing because it has supported a change in the way some nurse scholars/researchers have identified nursing in relation to its knowledge. Essentially, Polyani (1962) defined two different kinds of knowing, subsidiary and focal knowing. Subsidiary knowing defined a ‘personal knowing’ which Polyani described within the context of a Gestalt through which was derived personal meaning. He describes this ‘art’ of knowing and its related meaning, as an extension of the person. Polyani’s work has been used in nursing from a number of different perspectives (Dickoff & James, 1988; Lumby, 1991; 1995a; 1995b). Dickoff and James are critical of Polyani’s influence on nursing, as they are of Dreyfus’ influence on Benner’s work. They offer a critique based on Polyani’s work that I believe is taken out of context because they attribute a distinction based on values that should not be ascribed to Polyani’s work, and which is in fact more descriptive than hierarchical. The alternative view to the cognitive processing of knowledge represented by Lumby (1991; 1995a; 1995b), is one that acknowledges the effect of Polyani’s work in providing another perspective from which to understand the important art of knowing in nursing.

As the debate developed and alternative perspectives based on so called ‘soft’ philosophies and research paradigms were offered, first with Rogers (1970), then Paterson and Zderad (1976), Carper (1978) and Benner (1983), the seeds were sown for extending the basis of knowing. The theories of Watson (1985) and Parse (1981), based on phenomenological philosophies, complemented this progression and validated an alternative way of people
knowing and interacting with their world. Benner (1984) and Benner and Wrubel (1989) extended the debate with research into intuitive ways of knowing in nursing and relating it to caring in nursing. Despite Crotty’s (1996) criticisms of Benner, among others, that her work is not an accurate reflection of the Heideggarian framework that she uses, Benner’s work raised the profile of nursing knowledge within an alternative perspective, and situated the work of nursing within an ontological framework. The response by Darbyshire, Diekelmann & Diekelmann (1999) to Crotty’s critique of nursing research is a scholarly rejoinder that reinforces the complexity of Heidegger’s work and the need for open and continuing debate within nursing and between the disciplines.

Much of the discourse around nursing knowledge concerned the role positivist traditions of scientific inquiry and what the ‘new’ paradigm of qualitative inquiry had to offer nursing. Positivist science regarded knowing as purely cognitive and measurable while qualitative approaches tacitly acknowledged knowing in other ways. Application of an alternative paradigm to nursing and nursing knowledge has been well represented in the literature, but has fallen short of the enunciation of knowing as ontological. Quint Benoliel (1987) and Boykin and Schoenhofer (1991) came close to this next step in the debate, with Quint Benoliel identifying a difference between knowledge and knowing in nursing, contending that,

... knowing and knowledge in nursing are different entities. Knowledge consists of concepts, theories and ideas about an identified area of information, often presented in organised form in textbooks and monograph. Knowing can be viewed as an individual’s awareness of the complexities of a particular situation and draws on inner knowledge.
resources that have been garnered through experience in living. (1987, p. 151)

While this perspective advances the differentiation of knowing and knowledge it relies on the cognitive act of perception derived from experience. Boykin and Schoenhofer (1991) progress the concept further by linking nursing epistemology, practice and ontology through the use of story. Their work is based on Carper’s (1978) four fundamental ways of knowing and it is related to nurses knowing through personal reflection, which they say is essential to “being in nursing” (1991, p. 246). Unfortunately they have not provided a philosophical or theoretical premise underpinning knowing in nursing as ontology, rather they talk about nursing ontology, a somewhat different concept. The use of personal reflection does not invoke ontology as it is related to a mindful act when, as Heidegger (1926/1962) demonstrates, ontology is pre-reflective that is prior to any cognitive reflection. As with other nursing literature (Jenks, 1993; Munhall, 1993; Sandelowski, 1994) knowing is explored as a way of nursing, not as a way of Being, and, therefore, is more applicable to nurses and not to their patients. Knowing within ontology is universally applicable.

The work of Belenky et al. (1986) is often referred to in nursing literature and so has some resonance with nurses. The work examines women’s ways of knowing, and has contributed a great deal to uncovering the silence of women in society. As an exercise in exploring the concept of knowing it serves to reinforce the confusion that exists in explicating the value of knowing as ontology. In the introduction the authors describe how our basic assumptions about truth, reality and the origins of knowledge “shape the way we see the world and ourselves as participants in it” (1986, p. 3). This is reminiscent of Heidegger especially when they discuss historical and
current factors influencing future potential, “drawing on their own perspectives and visions, men have constructed the prevailing theories, written history, and set values that have become the guiding principles for men and women alike” (p. 5). However, there is no acknowledgement or systematic development of the ontology of knowing, despite the section on the ‘Inner Voice’. It falls somewhere between the two levels of knowing and, from one level of interpretation, loses some of the power that would be derived from a clear definition of the existential nature of the knowing of the women who were interviewed.

There has been even less work undertaken to explore ways of knowing in palliative care nursing. This area of nursing is relatively new as a specialty, although nurses have been caring for the dying for hundreds of years. Palliative care nursing adheres to the fundamental caring ethic evident in all nursing, although it does so within a multidisciplinary philosophy of care that actively promotes quality of life above cure. Kennedy (1998) argues that a gap exists in uncovering ways of knowing and nursing knowledge in palliative care. Although she suggests ‘knowing that’ and ‘knowing how’ are important contributors to the way nurses understand practice in palliative care, the research has been lacking in this area to unravel the dimensions of these two areas of contribution.

**THE NEED FOR A DIFFERENT KIND OF KNOWING**

Knowing has not been well defined in much of the literature and consequently has been portrayed primarily as a cognitive dimension. It is the intention here to identify another perspective of knowing, the ontology of knowing. It is not the intention to reject other ways of knowing but to offer an extension to current thinking. It is apparent that the concept of
knowing as ontology is implicitly referenced in the literature although it is not often represented. Thompson supports the prevailing view that “in philosophy, questions of knowing are central to epistemology, while questions of Being are central to ontology” (1989, p. 235). However, Bruyn (1966) clearly makes reference to a way of knowing that is central to personal existence, and that identifies with Comte’s discussion of knowing by personal identity - a type of knowing that involves identification with the surrounding world in a union between the two.

Knowing and the knowledge that underpins it has a rightful place in learning, acquiring new skills, making decisions and making some sense of, or prioritising, the overload of information that is available. Therefore, what role does ontology of knowing have? A clue to resolving this question can be found in Heidegger’s (1926/1962) assertion that existence precedes experience because the characteristics of Being are available prior to any cognitive awareness of them and therefore is the locus of knowledge. Primary or ontological knowledge, as distinct from cognitive knowledge, and as a form of knowing is located in the fore-structure or the potential possibilities of understanding described earlier in the chapter.

Perception is often regarded as a function of knowing and knowledge, although Heidegger (1926/1962) also makes the point that perception, as a modality of cognitive knowledge is unreliable because it relies on the interpretation of experiences. Molzahn and Northcott (1989) examined the literature related to perception and concluded that it is both sensory and cognitive in origin and is influenced by attitudes and beliefs suggested by experience. They also analysed the research related to patient/care provider perceptions with the conclusion that a “lack of perceptual congruency” (1989, p. 132) exists between patients, nurses and physicians, based on
environmental discrepancies. It could be argued that such discrepancies could not be totally avoided, given the individuality of human beings. The underlying implication is not just that the knowledge between nurse and patient was faulty. The knowing is often generated from the diverse attitudes and beliefs of both parties.

Lumby (1995a) critiques the construction of knowledge in nursing practice and suggests as the way forward, the connection between existence and knowledge, and politics and ethics within an embodied being. There is evidence of the application of embodied knowledge, for example Ford uncovers the knowing of post myocardial infarction (MI) patients,

As the post-MI patient learns to listen to his body and to interpret what it is saying the body’s messages may be in conflict with what the health care practitioner prescribes. In time he may come to trust and be guided by what his body has to say. In other words he may come to trust his own knowing. (1989, p. 178)

Body listening has also been described by Price who researched people with diabetes (1993a) and other chronic illnesses (1993b). She concluded body listening, gestalt and gnosis were ways of knowing a body in illness. Her research also made the distinction between the cognitive approach of knowledge and the existential approach of ontology, and acknowledged the primacy of ontology. She argues,

... this knowing appears to be a determinant in what body responses receive cognitive attention, or the amount of time and intensity with which the body
experience is attended to, and what is perceived as serious or not serious” (1993b, p. 50).

AN ALTERNATIVE VIEW

The most cited example of knowing in nursing is Benner’s (1983, 1984) work on how nurses know and make clinical judgements, and the extension of that work by other nursing scholars (Benner & Wrubel, 1989; Tanner, et al., 1993). Tanner and her colleagues, from their study, defined knowing the patient as knowing the typical pattern of response by the patient, the meaning for the patient of a particular event or situation, and knowing the patient as a person. They found that “knowing a patient is a central aspect of nursing practice ... knowing the patient is a primary caring practice” (1993, p. 279). This study supports a different way of knowing the patient, other than the “explicit, decontextualized data-based knowledge that constitutes formal assessments, yet it is central to skilled clinical judgement” (Tanner et al., 1993, p. 273). My study, however, is concerned with the primary or ontological knowing of patients as described by them, and how this can impact on nurses’ assessment, also critical in caring, ethical practice and sound clinical judgement.

Contemporary nursing literature makes frequent reference to a different kind of knowing, without unmasking it, but making assumptions that are evolutionary and in some way related to a person’s existence. Benner (1991) Sandelowski (1991; 1994) and Lumby (1991; 1995b), represent the most vocal proponents of this way of knowing. They engage in stories or narratives that were once the solitary way of expressing personal knowing, but tend to be forgotten in a modern world. Nurses have come to rekindle this kind of knowing that is, a way of interpreting the existential nature of the person being cared for. Sandelowski acknowledges this existential
dimension to knowing by arguing "narrative knowing is a means to know again what nurses have always known: whether nurse or nursed, we are the stories we tell" (1994, p. 25). Lumby (1991) proposes the development of new ways of knowing that do not require traditional epistemic boundaries, although does not proceed to identify or define another kind of knowing. Again, she similarly implies alternative ways of knowing, relating knowing to nurse knowing. Here, Lumby explores the contexts in which "nurses and nursing are constructed" (1995b, p. 4). She argues, "making visible the knowing involved in the doing is perhaps one of our greatest challenges, to understand what it really means when we talk about 'nursing another' and present it for critique" (p. 5).

HEIDEGGER, KNOWING AND ONTOLOGY

The literature as reviewed above identifies the lack of clarity in the underlying assumptions about knowing. Ontological knowing has been assumed (Lumby, 1991; 1995b; Sandelowski, 1994; Belenky et al., 1986) but not named and not uncovered for what it is. From a different perspective Taylor identifies the interdependence of ontology and epistemology, asserting that "ontological questions raise epistemological answers" (1994, p. 5). However, Heidegger clearly identifies and distinguishes knowing as ontology in its own right.

Heideggerian concepts of Being-in-the-world are fundamental to the argument that knowing can be ontological. Heidegger stresses that knowing in relation to the ontological structure of a person, is "different to the relation between subject and Object" (1962, p. 87). He argues that knowing has a priority in Being-in-the-world and is, therefore, ontologically constitutive of existence. Ontological knowing is what tacitly governs understanding, meaning, response and interpretation, and is often passed
over in silence (Kisiel, 1978). The interconnectedness of understanding, meaning and Being-in-the-world assures a place for knowing within the hermeneutic circle which Heidegger says is hidden, but the circle contains the “most primordial kind of knowing” (1962, p. 195). Heidegger’s notions of presence and presence in absence, illustrated by Olafson (1995) demonstrate knowing within ontology. It is the world and its entities that are present to us, or their absence that can be present to us, that forms the basis of understanding and meaning as Being-in-the-world. Within this circle of the interconnectedness of presence, absence, understanding, meaning and Being-in-the-world lies the primary way of knowing.

Heidegger makes some important points about the ontological features of knowing (1962, pp. 85-90):

- knowing the world as Being-in-the-world, primarily exemplifies the “soul’s relationship to the world”;  
- this relationship is experienced ontically;  
- knowing the world must be made visible as an existential modality of Being-in;  
- knowing the world has recently become “superficially” re-interpreted as a relation between subject and object. Subject and object do not coincide with Dasein and the world;  
- the relationship of the subject with the world is not created by knowing, what already exists comes to be addressed and interpreted; and  
- knowing does not arise from the way in which the world acts upon the subject.

Heidegger’s (1926/1962) thesis is that a person comes to know the world by the temporal and historical interdependence that make up culture, language
and attitudes. The primary way of knowing is invisible and is made visible through ontico-ontological experiences.

SUMMARY

Heidegger's hermeneutic philosophy provides the framework for this study because of the ontological unity between a human being and their world, that of being-in-the-world. It provides an alternative framework in understanding a person's relation to reality, not through the mind but as a way that things are present in a primary way of understanding. Most importantly for this thesis it challenges the construction of a cognitive view of knowing as the only way pain comes to be known to the person experiencing it, providing the background with which to re-examine a way of being-in-pain, and extending the dimension of nursing assessment of that pain. It is often said of phenomenology that it provides a means of uncovering what is taken for granted and hidden in silence. By the application of Heidegger's phenomenology, the silence of pain of those people who participated in this study, will be broken, because it will uncover the phenomenon of the way they know their pain.

But if familiarity shelters the mysteries of the world, self, time, truth and being, it also blocks access to them by generating a conspiracy of silence about them. For one thing, what is most familiar to us can in its unobtrusiveness be what is most likely to be overlooked. It is so near and yet so far. For another, the very variety of life militates against its simplicity. Life is so daily, and in our concern for the particularities of daily existence the more comprehensive sense that we have of what it means to be can easily lapse into oblivion. One might even say that there is a natural attitude which obliterates
the difference between particular beings and their being. Kisiel, 1978, p. 18

The processes by which this study uncovered the knowing of individual pain and the ontological meanings that were generated will be discussed in the following chapter.
CHAPTER 4

THE RESEARCH APPROACH
THE RESEARCH APPROACH

Is science the measure of knowledge, or is there a knowledge in which the ground and limit of science and thus its genuine effectiveness are determined?
Heidegger, cited in Bleicher, 1982, p. 3

INTRODUCTION

This chapter will discuss the research process undertaken to develop an understanding of the ways of knowing of people with cancer pain in a palliative care setting. The process is affected by decisions made at every stage; beginning with the research question, the methodology, access, data collection, analysis and presentation. In making those decisions I was very much guided by the literature and my own beliefs and values. Decisions made in the research process reflect the rigour of the study and pre-empt any action or process within the study. This qualitative study follows the philosophical framework of Heideggerian hermeneutics, in that this philosophy is used as a framework, but that framework is, necessarily, an interpretation. A Heideggerian framework was chosen because I felt the silent and hidden aspects of pain stemmed from the very existence of the person, suggesting an unknown quality to pain. Initially not able to be articulated, this sense of existence was present but suppressed by the busy daily activities of caring for these patients. My reading and philosophical leanings led me to Heidegger, who, although difficult to read, paradoxically
brought some light to the unarticulated questions I had been unable to frame. From this point, many decisions needed to be made to define a sense of the whole study, underpinned by the relevance of qualitative research to the philosophy and practice of nursing.

The value of qualitative methodologies for nursing research is evident, as nurses become increasingly receptive to the patient as a person, patients’ concerns and issues, and the context in which they live out their concerns. A qualitative perspective supports multiple truths, allowing for the interpretations of the individual to be heard. A perceptible philosophical shift from epistemology to ontology is occurring in nursing (Silva, Sorrell & Sorrell, 1995), with the result that quantitative methodology is seen to be limited in its application to the many areas that are now considered integral to nursing (Koch 1995; Lawler, 1991; Parker, 1992; Taylor, 1992).

Many nurse researchers have addressed the question of achieving scientific adequacy or trustworthiness of a study (Koch, 1994; Meleis, 1996; Rose, Beeby & Parker 1995; Sandelowski, 1986; 1993). The question of rigour in qualitative research is a vexed one underlined by the fact that a blueprint for conducting, analysing and presenting qualitative research does not exist because of the diversity of such research. The work of Guba and Lincoln (1981; 1989) has informed much of the nursing debate surrounding issues of rigour, and their fourth generation evaluation process has been adopted or adapted to some nursing studies (Jasper, 1994; Koch, 1993; Rose, Beebe & Parker, 1995). However, Taylor’s contention that “there is no verification procedure we can fall back on. We can only continue to offer interpretations” (1987, p. 15) remains relevant. Guba and Lincoln (1989) offer a process of validating methodological construction of phenomenological work. They contend that constructions are open to
multiple interpretations, are never complete and do not remain constant over
time. It is, therefore, a responsibility of the phenomenological researcher to
explain how a particular construction or interpretation was achieved.

ACHIEVING RIGOUR
Application of the decision trail, or audit of the study, provides for
accountability for the decisions of the researcher in making interpretations
without the orthodoxy of quantitative verification procedures. The audit of
the dependability or consistency of a study, through incorporation of a
decision trail, forms part of Guba and Lincoln's thesis (1989) which offers a
process and method for achieving evaluation of a constructivist or
qualitative study. Part of this process includes the criteria for establishing
trustworthiness. Guba and Lincoln acknowledge them as parallel criteria,
that is, criteria that have their "roots and origins in positivist assumptions"
(1989, p. 245). They are:

• truth value or credibility. A number of indicators are given to track
credibility including member checks and researcher subjective reflection,
and the use of a field journal. In this study it was impossible to achieve
regular and formal member checks because of the deterioration and
unpredictable progress of the patients, although a field journal was used.
Sandelowski, who has adopted Guba and Lincoln's process in some of
her work, challenges member checking as a means of enhancing
qualitative work saying that it "believes the deeply theoretical and ethical
difficulties...[and] may serve paradoxically to undermine the
trustworthiness of the project" (1993, p. 4).
• applicability or transferability which refers to the adequacy of description of the context to facilitate judgements by readers who may wish to apply the study to other situations. I believe adequacy of description is essential as a means of achieving a decision trail. As Guba and Lincoln point out, the “burden of proof” (1989, p. 241) for transferability lies with the reader.

• consistency or dependability which is concerned with data processing. The audit or decision trail is suggested as a means of tracking decisions and changes made to the research process.

Strategies suggested by other researchers to achieve methodological rigour include, adherence to a philosophical framework, thus avoiding method slurring (Rose, Beeby & Parker, 1995), and processes that draw on tradition and a body of knowledge and insights that support phenomenological scholarship (van Manen, 1990). Sandelowski (1986) argues for a balance between achieving scientific rigour and an artistic or aesthetic approach. In applying rigour to this study, I have adopted a number of criteria:

• adherence to the ontological philosophy of Heidegger in the conduct of the study and its analysis;

• inclusion of contextual description;

• maintenance of a field diary, as a means of subjective reflection and demonstrating researcher bias; and

• explanations of decisions and their rationale by adapting Sandelowski’s twelve point process for achieving “auditability” (1986, p. 29) in
qualitative research, which is adapted from Guba and Lincoln's analysis of a constructivist paradigm (1981).

**SIX POINT PROCESS OF METHOD**

In adopting the above criteria I make clear my beliefs that qualitative researchers need to be accountable while not being directed by the rigidity of rules. As a way of defining both the research process and the progression of events and decisions, the research method used in this study will be discussed using the following sub-headings adapted from Sandelowski’s (1986) process discussed below.

1. **How the Researcher Became Interested in the Subject Matter of the Study**

The research question evolved from my experience working in Oncology and Palliative Care and information from the pain literature. Frequent reference to the literature was part of an ongoing learning process necessary to provide care for these patients and it became apparent that practice was not in keeping with the literature in relation to pain assessment and/or management. It is my opinion that at times pain was not relieved adequately. Assessments, when made by nurses, usually consisted of asking, “do you have pain?” and sometimes “how bad is it?” and “where is it?” These questions did not address the multiple dimensions of pain. I could see patients troubled by their pain and began to wonder what they knew and understood about their pain: something I did not know and other nurses did not know. After reading Heidegger, the sense of wondering became more tangible by Heidegger’s words: “Being inside which knowing possesses has its own character of Being grounded in the kind of Being which belongs to the subject” (1962, p. 61). This was the precursor to the eventual research question and the adoption of a qualitative methodology.
because, as Rabinow and Sullivan (1987) have argued, human phenomena cannot be comprehended through linear cause and effect models.

2. How the Researcher Viewed the Thing Studied
As qualitative research is value laden, it is incumbent on researchers to declare their values, beliefs and perspectives about issues as they arise in the process.

‘The thing studied’, the phenomenon of knowing cancer pain had a great impact on me, although not to the same extent as it did to a patient who had pain. It was not until I began this study that I took the opportunity to reflect on this experience and the silent effect it had, and realised that experiencing cancer pain is a complex phenomenon, not just physically, and not only confined to the moment first experienced and thereafter. These experiences are the mirror that reflects a primary or immediate knowing through revelation of the antico-ontological dimensions, as discussed in chapter three. I also believe strongly that nurses have a duty to relieve pain and it is a failure on the nurses’ part if a patient has pain at a level that is intolerable to him or her. Unfortunately pain assessment and management can become routinised and mechanical because of a variety of reasons, including time constraints, lack of knowledge, and also the silent internal agitation nurses can experience when confronted with constant pain. Anecdotal and empirical evidence exists that suggest working with patients who have constant pain can have a negative effect on the nurses’ performance (Wilkinson, 1991). Working with patients in pain either from cancer or its treatment affected me differently to working with patients in pain from surgery. Even though there are many similarities, my experience and observations suggested that cancer pain reached a different level of existence for the experiencing person, possibly related to its connotations of
dying and a person’s perceived inherent powerlessness to change that situation. Given my belief that nursing is an holistic process and that patients’ issues, concerns and experiences are existential and need to be considered, I adopted an ontological framework as a vehicle to discover the being of knowing of cancer patients with pain.

3. The Specific Purpose of the Study
The purpose of the study was two fold, first to construct a research process to answer the following questions:

- what are the ways of knowing about cancer pain from palliative care patients’ perspectives? and

- are these ways of knowing important in the assessment of pain by nurses?

The second purpose was to provide a framework that would re-situate the notion of knowing from an epistemological to an ontological framework, underpinned by Heidegger’s (1926/1962) explication of knowing the world as a primary mode of Being-in-the-world. Knowing the world is the foundation on which understanding and meaning rest.

Understanding was integrated in the study in three ways; the understanding patients in the study had about knowing their pain; the understandings I brought to the process as researcher and the interpretive and contextual relationship between the two. Rabinow and Sullivan (1987) explain understanding as being rooted in self-definitions - who we are - and is made possible because of pre-understandings, which accompany Being, our existence within the world, and, therefore, our knowing the world.
Heidegger (1926/1962) refers to the hermeneutic circle to express this kind of existential understanding. I have suggested in chapter three that this study forms a hermeneutic circle and each part of the process forms a smaller circle that contributes to the whole, larger study. This view is supported by Denzin (1989), who suggests that an interpretative circle surrounds the research process, similar to Heidegger’s idea that basic concepts and questions are part of the research and that they “determine the way in which we get an understanding beforehand of the subject matter ... every inquiry is guided beforehand by what is sought” (1962, p. 24). The research circles are a composite of the researcher’s worldview, the literature and primarily, the researched.

Denzin (1989) interprets Heidegger by identifying three circles of understanding, the researched; the researcher’s which is not, and does not necessarily become the same as the researched; and the research process. Understanding from these three perspectives identifies the nature of understanding within phenomenology. Crotty (1996) also argues that the hermeneutic circle is not one and the same for both the researcher and the researched. Denzin (1989) explains that the researcher and the researched are in the centre of the research process within their own circle, implying double, yet separated and interfacing circles. The patient is within their life story and the researcher is within his or her interpretation of the story, filtered through personal life meanings. There is some overlap when the researcher is able to have the same understanding as the patient. However, Denzin makes clear that the circles can never overlap completely because the patient’s experiences can never become the researcher’s; “the best that can be hoped for is understanding” (1989, p. 54). It becomes the responsibility of the researcher to achieve understanding, not by leaving behind or bracketing his or her worldview, but by endeavouring to expand
that worldview to encompass the interpretation of another person, although not necessarily to adopt another person’s worldview. A model based on Denzin’s interpretation of the research process is presented in Figure 3.

Figure 3: Diagrammatic Interpretation of Denzin’s Research Process
In attempting to understand the patients’ knowing about their pain, I must identify my interpretations and understandings, which I have mentioned above and will continue to disclose within Sandelowski’s criteria for applying rigour while explicating the research methodology.

4. How the Participants Came to be Included in the Study and How They Were Approached
I interpret this criterion in three ways; access, sample and ethical structure, and I will proceed to discuss each individually.

Access: Prior to approaching patients, the study was approved by the University Higher Degrees Board, the University Ethics Committee, the ACT Health Ethics Committee and Hospital Ethics Committee.

The six patients who participated in the study were each approached because they had pain related to their cancer and were involved in a palliative care program, either through the hospice, the home based palliative care service, or chronic pain clinic. Each patient was approached initially by myself or another palliative care nurse. A condition imposed by the Director of Nursing for Community Nursing, who manages the home based palliative care service, was that any patient from that service had to be approached initially by a nurse from that service. If the patient agreed to have more information about the study and consented to the nurse supplying contact details to me, then I would ring the patient and make an appointment. Patients from the hospice were approached by me directly, as I was a member of staff. Only one patient was approached from the chronic pain clinic, which was attached to the major teaching hospital in the area. The nurse/counsellor who managed the clinic, initially approached the patient for me.
Criteria for inclusion in the study were, that the patient:

- had pain related to cancer or the treatment of cancer;
- was receiving palliative care;
- spoke English;
- was not close to dying, as near as could be assessed;
- was not clouded mentally by drugs or cerebral tumour;
- was able to speak unaided and without difficulty to him or her; and
- was able to give consent freely.

These criteria were imposed to protect the rights of the patient and to ensure appropriate communication and hence adequate data generation. The rights of the patient are better addressed when the patient fully understands and is able to give informed consent (Minichello, et al., 1995; Streubert & Rinaldi Carpenter, 1995).

Each patient was given a package containing an information sheet (see Appendix A) with steps illustrating what the process would involve, contact details and a consent form (see Appendix B). Each form was approved by the Ethics Committees. The four step process I followed was:

- initial introduction of the research to the patient by myself or another nurse;
- brief discussion about the study and, if the patient was interested in finding out more, presentation of the package;
- follow-up when convenient for the patient to discuss any issues for them and to clarify what was involved; and
- gaining consent - signing the form. Each patient was provided with a copy.
Not wanting to rush the process as the patient might be exploited at a vulnerable moment, time was provided for them to think about and discuss their concerns with their family. Equally, I was very mindful of the timing of any interaction with the patients, given the unpredictable nature of how they would feel, physically, from day to day. I would at times suggest to the patients, if I felt they might not be well enough at the pre-arranged time of the interview, that it could be postponed. On one of these occasions, Mr Schmidt said he had pain, “but what’s new? I have had pain all my life, so you may as well come in”.

I also had access to patients’ families, notes at the hospice and to the nurses caring for the patients in the other settings. I tried not to listen to the nurses’ stories prior to the interviews believing this might have confused my understanding of the nature of the patients’ stories.

**Sample:** The non-probability sampling strategy adopted was purposive (Minichello *et al.*, 1995), that is, participants were approached and selected because their intimate knowledge of cancer pain, their availability, and their current life experiences met the criteria for the study.

The sample consisted of six people. In the course of data collection, I approached twenty patients. Apart from the patients who completed the interviews, I had consent from seven others who completed the four step procedure outlined above. Unfortunately these patients either deteriorated or died ‘suddenly’. Two patients who died were about to be discharged from the hospice because their condition was stable, and we had agreed to conduct the interviews in their homes. I rang one patient at home as arranged to make a time for the interview, only to be told by his daughter that her father had died suddenly during the night. These incidents
highlighted the difficulties of conducting research with palliative care patients. The remaining six patients, with whom I approached and discussed the study, opted not to continue for personal reasons. The decision to conduct the study with six people was not an easy one. A statistical formula that dictates sample size does not exist in qualitative research, the logic underpinning sampling strategy is tied to the individual study and therefore needs to be transparent and is an important aspect of the research process (National Health & Medical Research Council, 1995). Two main factors contributed to the decision to stop data collection: the quality of the data from preliminary analysis, and the difficulty recruiting participants.

Because of the nature of qualitative research, the decision about sample size is made during data collection and analysis rather than before the process has begun. A sample size may be projected at the beginning although it will be modified during the research process in response to the quality of the data and the way the process is shaped by the participants (Benner, 1994b). Sandelowski (1995a) offers three factors for consideration to assist qualitative researchers in the decision about adequacy of sample size. These factors are; the aim of sampling, the type of purposeful sampling and the research method employed. In qualitative research the sampling issues are underpinned by the need to collect information rich data that provides a deep understanding of events, incidences or experiences. The richer the data, the less the number required in the sample.

Qualitative research is directed to experiences rather than people per se, requiring the sample size of the study to reflect a richness of information (Sandelowski, 1995a). Sample size may refer to the number of data generating events rather than to the number of people involved, although
Morse (1994) has recommended that phenomenologies directed towards uncovering meaning in experiences, include about six participants. Morse (1989) questions the status assigned to saturation of data in qualitative research, suggesting that it is a myth. Therefore the issue of saturation was not a factor in this research study, rather the depth of understanding gained from the data was primary in the decision about sample size. The number of patients and data collecting events for this study were sufficient to generate a richness of data from which to explicate an understanding of ways of knowing cancer pain.

**Ethical Structure:** Ethical considerations began with issues related to confidentiality, informed consent, anonymity, and rights of refusal. Measures taken to protect these fundamental rights of participants were included in my original research proposal and subsequently accepted by the various ethics committees, mentioned above. Two of the ethics committees made the point that the patients may find it disturbing to discuss their pain, and that I should be aware of this and have appropriate support available as I was not to engage in a counselling role. I believe there are two sides to this. While it is important not confuse the issues of research and counselling for the benefit of the patient as well as the research outcomes, counselling is also an everyday event for experienced palliative care nurses, and counselling in some form is part of the relationship with the patient. It is similar in the research relationship and it is important for institutional ethics committees to understand what ‘upsetting’ means in context and to determine if the researcher has experience with this. As it happened Ida James and Maggie Peters did have times when they cried quietly as they talked about things that mattered to them. I sat with them quietly at these times, supporting them in their grief, with an openness to allow them to explore those issues if they so chose. Ida chose to do this on one occasion,
which I did not record to protect her privacy. I later spoke with the social
worker who was working with the particular patients about the incidents, as
this was a requirement of the Ethics Committees, and of which the patients
concerned were aware and gave approval.

A number of other ethical issues related to researching a potentially
vulnerable group were not raised until I began to select participants to
approach. The issues raised for me during the study were:

- which patients to approach, as they were all potentially vulnerable
  because of the unpredictable course of their illness and all were very
  sick;
- the potential conflict of interest between caring for these patients and
  requesting to undertake research with them, which had the potential to
  undermine the principles of consent; and
- the balance between doing harm and doing good.

There is a dearth of literature appertaining to these problems, although
Aranda (1995) has discussed similar ethical considerations in palliative care
research. I resolved the issues raised by; reference to the literature, the
National Health and Medical Research Council (NHMRC) guidelines for
researchers (1992), and by personal reflection. When a patient refused to
participate some of my colleagues urged me to ask again because they felt
the patient’s refusal was related to how they felt at that particular time. I did
not follow through with either of these suggestions. I was also concerned
about the subtle dynamics that could operate because of the professional
relationship I had with most of the patients that I interviewed. I was very
aware not to inconvenience or pressure patients I approached to participate
in the research because of their vulnerability and because, for many, I was
their carer. I resolved the issue of potential nurse/researcher conflict by adopting the four step consent process, described above. Following the consent process I needed to be convinced that those who consented did not do so just because I was one of their nurses. I did this by recording in my journal my immediate thoughts, feelings and impressions after discussing the research and the consent processes to each person. I would reflect on these entries to determine the motives as far as was possible of any of the patients who agreed to consent. I was satisfied that those who did not want to participate felt comfortable in saying so and those who ultimately consented did not feel coerced in any way. If I sensed at any stage some doubt about participation from the patient I would always provide the option of not continuing.

When conducting the interviews I was not in the role of the nurse, although the patients at the hospice did not appear to separate the two roles, creating a dilemma in my mind about whether to be a nurse or researcher in particular situations. Many times patients would ask me to assist them, which I found very distracting although I could understand why it occurred. Legally I was not able to perform the duties of registered nurse as all the interviews were conducted in my own time. On those occasions I would enlist the assistance of other nurses. The dilemma also arose when having interviewed the patients and acquiring information about them and their pain, should I use and share this information in my role as nurse to improve their care. Borbasi (1994, 1995) also identified a similar dilemma and resolved to be both nurse and researcher. Gardner addressed the question of the nurse as researcher and concluded that,
By harnessing the skills and human sensitivity of nursing practice, the nurse researcher can position the self as nurse and researcher, and enable the person being interviewed to adopt the discourse position that enables them to talk with freedom and comfort about intimate and sensitive topics (1996, p.157)

In relation to my own dilemma, I felt satisfied that the patients who were at the hospice that I interviewed, were receiving appropriate medication. With their permission I asked a pain counsellor, whose work covered all aspects of pain, to visit with them as part of a multidisciplinary approach to pain management. In this way, I was not divulging confidences or challenging the confidentiality of the research process. The pain counsellor following her own assessment, would make recommendations to the staff about further management that incorporated broader pain concepts.

In relation to other dilemmas, I repeatedly questioned whether interviewing these people was causing them any harm, particularly when, during an interview most of those interviewed asked for pain relief. I was reassured by all the participants that they liked to talk about their pain. As Ida James put it: “I love to talk about my pain with you because I know you’ve got the time to listen, because I don’t think the staff have the time and so I don’t like to hold them up”. I often checked with the participants that it was all right to continue and offered them a way out if they wanted, but I was reassured by each that they wanted to continue. Most were grateful for the opportunity to contribute and as Veronica Hayes said, “if it will help the nurses or other patients then I’m happy to do it”. Ida said it made her feel useful for a change.
Other issues that were raised during the interview process concerned consent, and the advocacy role of nurses caring for patients involved in research. Many of the patients who participated in the research did not want to go through the consent process outlined above. Once explained to them, they just “wanted to get on with it”, possibly because they knew their life was limited and activities take on a different sense of time for them. While it is important to have appropriate and informed consent, many elderly and sick patients do not want to go through the time or effort of a lengthy consent form or process an issue also raised by Madjar and Higgins (1996) in their research with elderly people.

During the process of finding and selecting patients to participate, I discovered that many nurses were not interested in the potential impact of research on the patients for whom they were caring. Advocacy by the nurses for patients seemed to be diluted or non-existent when it came to research. Nurses working in a hospital from where I sought research participants would at times guide me to patients who were clearly too unwell to participate, or would urge me to come back another day “when (the patient) was feeling better”, if a patient did not want to participate. Ultimately, I did not involve patients from that particular hospital, as generally they were too acutely ill.

The processes of conducting this research at times led me to feel uncomfortable, specifically when initially approaching such sick people, because of the implications it may have for them. Most commonly this occurred if I did not know the patient, as I felt I could not always rely on the assessment or advocacy of others, and sometimes found that I was approaching patients who were very physically distressed. I believe more debate is necessary around ethical considerations of research with
potentially vulnerable people to ensure adequate protection for them and better guidelines for researchers and clinical staff.

5. Data Collection
Data collection proceeded over a seven month period because of the difficulties encountered recruiting patients and allowing for appropriate time in the process required by their condition. Data were generated by in-depth interviews and from diaries kept by some of the patients. Four patients were interviewed a number of times which were audio recorded. The interviews lasted thirty to ninety minutes, depending on how the patient felt at the time. Two patients consented to one long interview only. The data collected became text for interpretation and will be referred to as text.

Interviews: Interviews with each patient took on a conversational mode while maintaining some direction over the process to keep to the broad topic of pain (Minichello et al., 1995; van Manen, 1990). Interviews were conducted as in-depth semi-structured interactions in that the patient was initially asked to tell me about his or her pain. Depending on the content of their story, I would ask them to clarify a particular point they had mentioned and that I did not understand, or to expand on some aspect I found interesting, as usually occurs in a conversation. The direction of each conversation was driven by the patient, however, on occasion, I took some licence to keep to the topic of pain. An example was when Maggie Peters began to discuss the political influences on the financial aspects of cancer research, I gently redirected the conversation back to her pain. With these many interruptions that included breaks for refreshment and to go to the toilet, I was often with each patient for two or three hours to gather sixty to ninety minutes of interview.
Using a Heideggarian philosophy, the focus of research is on the meaning of Being. In this study the meaning of the being of knowing cancer pain, as it is understood pre-reflectively, or as it is immediately or primordially given, is the focus. It would be difficult to ask a person to tell what they understood pre-reflectively, as they would probably not grasp the philosophical implications. Patients were asked to talk about their pain in terms of the meaning it had for them and what issues mattered to them, either in the past, present or future. The topic was put to them in this way to assist the patient to reflect on the nature of their understanding of their pain.

**Diaries:** Five of the six patients were asked to keep a diary for a period of two weeks. They were asked to record in the diary whenever they felt they had something to say about their experience of pain. It was hoped that this would provide another form of data collection which would not be influenced by my questions or presence. I did not ask Ida James because she was legally blind and, although she could read some things, it would have been a struggle for her to keep a diary. Bert Schmidt declined to keep a diary, as did Jack Taylor because they were not ‘writers’. I have recorded in my notes that Bert’s response to the diary was: “if I got anything to say I say it, I don’t write it. Never have”. The diaries have proved useful as a source of new data and as one means of data checking, which is discussed below.

**Research Notes:** I kept a journal to record issues that arose for me, such as my reactions to particular instances that might influence my interpretations, as well as to record non-verbal situations and behaviours during interviews. An example of this related to Maggie Peters. Maggie asked to keep a diary for the research, even though her health was obviously deteriorating. I had left a note in her chart, so the diary would not be lost if she died, and she
also mentioned it to the other nurses. I was not at work when Maggie died, but I received a telephone call to notify me. I collected the diary immediately to protect her privacy. The last entry in the diary contained an account of the physical abuse she suffered during her marriage many years earlier, but which was permeated by a positive outlook towards the future. It was written in the third person, the same style that punctuated her interviews and her diary. I have recorded in my diary the impact this had on me, which was quite profound, as none of the staff knew anything about this aspect of her life. It was quite a revelation and yet obviously something that she had carried with her. It was the last thing she ever wrote before she died. When I was analysing Maggie's text, it was helpful to read my initial feelings about this entry and compare them to Maggie's words and so arrive at an understanding based more on Maggie's story than my emotions.

Phenomenology looks beyond the subjective attitudes, feelings and emotions of the individual in order to elucidate the phenomenon in question (Crotty, 1996). Although Crotty is referring to those interviewed, it is also applicable to the researcher. It was for this reason I kept a journal as a means of reflecting on, and separating, my emotions from the patient's experiences, through which I was able to discover the phenomenon. I am sure that the spirit of each person interviewed had an unconscious effect on my interpretations, just as much as the words spoken, contributing to the intersecting circles of my understanding articulated by Denzin (1989) and referred to in chapter three.

6. Text Analysis
Heidegger's phenomenology does not provide a method or technique for analysing text except by informing the process with an understanding of interpretation. Sandelowski (1995b) offers a preliminary process of analysis
but pre-empts this with words of caution to avoid cookbook applications of techniques that have the potential to separate data collection, preparation and analysis. She argues that these three aspects of analysis have a temporal and conceptual overlap, which if technically separated could distort inherent meaning. Her caution also extends to avoiding the assumption that a product of qualitative research includes all the data collected.

The purpose of text analysis process in phenomenological studies is to put the data into a more usable form that allows for interpretation. Sandelowski observes that both text preparation and analysis are viewed as “operations that (re)present and (re)organise the data into forms that will permit interpretation” (1995b, p. 372). It is important to state that text interpretation is the researcher's understanding of the text based on the words and contexts, both physical and personal, of the participant. Patton (1990) describes the resulting interpretations as making the familiar more familiar, making the familiar strange and/or revealing what is hidden.

I have adopted a process for analysis in this study that is grounded in Heidegger’s hermeneutic phenomenology by utilising the essential structures that he identifies as forming the basis of his philosophy. These structures have been clearly articulated by Heidegger, (1926/1962) and their relevance is argued in chapter three. They are Dasein and its three-fold structure; understanding; knowing and the self, as expressed in Heideggarian terminology as: attunement (moods); discourse (articulation); and pressing into new possibilities (for-the-sake-of) (Dreyfus, 1987). Other concepts discussed in chapter three that are part of Heidegger’s philosophy are integrated within these three structures. The method used is adapted from Sandelowski (1995b) and van Manen (1990). The process involved; data preparation, preliminary analysis, defining significant statements,
establishing themes that identify a common background, and defining themes for the individual within the context described in chapter three. These will be discussed below.

**Data preparation:** The data preparation involved verbatim transcription of interviews including behavioural gestures, e.g. crying/laughing. Interviews were transcribed, as soon as possible following the interview. Resulting questions concerning unclear statements or intentions were noted for clarification with the patient when possible. Following transcription, non-verbal components such as gestures, restlessness, smiling, frowning were added from my notes. The completed diaries were also transcribed.

The addition and omission of non-linguistic features and placement of punctuation have a bearing on the preserved data. Mishler (1990) observed that all of the non-linguistic features of an interview are impossible to preserve. These features often give sub-conscious weight to an interpretation. It therefore needs to be acknowledged that interpretation by the researcher begins at the interview and continues through all the following stages.

**Preliminary analysis:** This phase included preparation and proofing the transcripts against the taped interviews, listening to the interviews, reading the notes and diaries to get a sense of the whole. This process was repeated for each patient. Notes were made in the margins or phrases underlined if they generated ideas or thoughts. These first two stages were adapted from Sandelowski (1995b).

**Defining significant statements:** Statements were judged to be significant if they generated ideas about the phenomenon of knowing pain against the
four criteria identified from Heidegger’s work, or if they met one of Heidegger’s criteria for knowing as ontology (1926/1962). Briefly, these criteria informed by Heidegger (1926/1962) and Kaelin (1988), are:

- encountering entities as they are present and/or absent to the person, not as seeking them out would reveal them;
- being in continuous interaction with the world;
- having a temporal and/or historical understanding of being-in-the-world; and
- being alongside - at the present time.

**Establishing themes:** This stage involved isolating statements that helped to reveal the phenomenon being studied. I used van Manen’s (1990) method of a detailed reading approach to isolate significant statements. I was not able to use the patients to check my interpretations because of the limitations outlined above. As I had more than one interview with most patients, and some used a diary, I was able to look at themes that recurred, validating to a degree the identified themes. Of course, the themes remain my interpretation, although influenced by patients’ gestures, verbal tone, body language and field notes as much as by the words of the transcripts, and by constant referral to the phenomenon being uncovered. As this research is not representative of a defined population, individual understanding and meanings of self are valid, and this is in keeping with Heidegger’s philosophy as discussed in chapter three.

The themes of each patient’s data were reviewed for their significance in relation to the phenomenon of knowing pain. Those that did not meet the criteria, set out above, or that did not capture the meaning of patients’ knowing their pain, were rejected.
Themes were identified as the common ground of meaning of the participants in relation to their cancer pain. Constitutive features of each theme were identified from all texts from each individual patient. The resulting themes uncovered the ontological dimensions of the hermeneutic circle that expressed the meaning of Being of knowing cancer pain. From this point themes were collectively interpreted within Heidegger’s (1926/1962) ontological structures, thus returning full circle to the meaning of Being in the ways of knowing cancer pain. The activities and concerns of the participants in relation to their pain informed the ontological meaning.

Texts from each patient were then isolated to resolve the place of self within Heideggarian phenomenology as a “pattern of concernful activity” (Young 1997, p. 58) in relation to the impact of assessment by the nurse. The individual nature of the research results that underpins this chapter is consistent with Heidegger’s theory argued in chapter two and also with nursing discourse and practice. Pain assessment must be based on individual needs and meanings as presented in chapter two and is also consistent with the nursing ethos. Phenomenological meaning and personalised care are integrated, a phenomenon supported by Brown (1986) and Swanson (1991). Brown found that patients valued non-routinised caring practices by nurses and Swanson defined ‘knowing’ as a dimension of caring as it understands meaning for another person.

**Presentation of data:** The presentation of data follows the pattern of analysis. The data is presented, in chapter five, in the first instance as universal ontological patterns that define the meaning of Being and of knowing cancer pain. As part of uncovering meaning, the individual
responses within a common background are presented in respect of the importance of the concept to pain assessment by nurses in chapter six.

SUMMARY
The method adopted to apply Heidegger's framework is a composite structure that supports the philosophical framework in addition to uncovering the phenomenon in question. It also respects the 'self' as part of the pattern of Dasein and fulfils the role of qualitative research to identify common structures, although it is recognised that the results are not representative. Questions related to the ethics of research with chronically ill and very sick patients are also raised.

The following chapter will introduce the participants and commence the interpretation about the meaning of knowing cancer pain.
CHAPTER 5

KNOWING PAIN
KNOWING PAIN

Our familiarity with the workshop is just a specific case of our general being at home or “dwelling” in everyday environments — knowing how to position and move ourselves, what to do and say, and so on.

Harrison Hall, 1998, p. 132

INTRODUCTION

Heidegger’s hermeneutic phenomenology is the guiding framework for this study and some of the concepts that underpin Heidegger’s philosophy were discussed in chapter three. In chapter three I have identified that Heidegger’s mission was the explication of the meaning of Being. In conjunction with this are the aims of this thesis identified in chapter one, which are to delineate the ways of knowing about cancer pain from palliative care patients’ perspectives, and to relate these ways of knowing to better assessment strategies by nurses. The conversations I had with the six patients and the information from their diaries generated the data for this study. From these sources of data, themes were generated that support the concepts of Dasein, understanding, knowing and the self, concepts that contribute to explicating the meaning of Being. The participants in the study are presented first, followed by the themes generated by the data. Heidegger’s aim and the aims of this thesis come together in the development of the framework and its application to the analysis and its presentation. In this way the analysis has supported Heidegger’s philosophy and articulated the importance of knowing pain in the management of that pain.
The second research question identified in chapters one and four in relation to pain assessment, will addressed in chapter six, in conjunction with the notion of self as it crystallises out of the “conforming public self” or *Dasein* (Dreyfus, 1987, p. 266).

**INTRODUCTION TO THE PARTICIPANTS**

Presenting the participants first is designed to provide some background information from which the themes presented below can be understood within a context. Information about the participants, their surroundings and my research notes assist to provide the background and to inform about the important connection with other things in the immediate world of the participants.

**IDA JAMES**

Ida James was ninety-two years old and until just prior to her admission to the hospice, lived independently in a flat. Her son lived near-by. She had been well and active when she was diagnosed with a malignant abdominal mass. Her eyesight was poor and she was classified as legally blind. She spent much of her time, prior to admission to the hospice, with friends and family, socialising and helping them where she could.

Ida had not spent much of her time in hospital, but because of her pain, her advanced age and restricted eyesight she had reluctantly agreed to remain at the hospice until she died. When she was interviewed she was reasonably mobile, articulate and independent. However, she did have days when she would stay in bed because she felt so unwell or had considerable pain, which was extremely exhausting for her. She then slept much of the following day or two.
Ida was sitting in a water chair when I first interviewed her. She was wearing a nightdress and shawl, surrounded by a phone, drinks, a variety of jars of sweets, jams, condiments and family photos in old heavy frames. She was of slight build with wavy white hair and remarkably agile in her movements. At times during the interviews, the phone rang, and after brief salutations Ida would say that she was “chatting to the nurse” about her pain, and she would call back. No doubt this caused some consternation to whomever was on the phone.

Ida was very keen to be interviewed, however, finding a ‘good day’ was difficult at times, especially as she had many visitors when she was well and rested. Ida died soon after the last interview was completed.

**VERONICA HAYES**

Veronica Hayes was a 54-year-old woman who had been diagnosed with breast cancer fifteen years earlier, when she had a mastectomy and chemotherapy. She remained well until five years ago, when she was diagnosed with bony secondaries in the spine. Since then she has received radiotherapy a number of times to shrink the tumour and keep the pain under control. The treatment has been successful each time, although each time it recurs there is more deterioration in her spine. I first met Veronica when she was admitted to the hospice in extremely severe pain, its first recurrence in two and a half years.

Veronica was originally from England and had been in Australia for thirty two years. She had been divorced for some years and had a twenty seven year old daughter, who lived with her. I had three interviews with Veronica and she kept a diary over a long period because the pain would
settle down for a while and then recur. She asked to keep it going when her pain recurred.

Veronica always wanted to “have a chat” and spoke freely about what was on her mind. She did not have many personal items at the hospice and was always very keen to go home as soon as possible. When I visited Veronica at home she appeared to be more relaxed and comfortable.

HERBERT SCHMIDT

Herbert Schmidt was a sixty seven year old man who had been diagnosed with prostate cancer some years earlier. He had since developed bony metastases and continued to be treated palliatively. He was an inpatient at the hospice because he had back pain from the metastases with leg weakness. He had been at the hospice for about a week when I first asked him about being interviewed. He said he did not mind except he could not understand what he knew that I would not already know. I will refer to him as Mr Schmidt as he preferred to be addressed in that way.

Mr Schmidt was of German nationality and had been in Australia for forty years. He was a retired carpenter, currently lived with his wife and had two children who were married and lived some distance away.

I have recorded in my diary that he did not waste words, he was very matter of fact, said exactly what he thought and was always definite about what he said. It was for this reason that I used prompts to encourage some conversation, as once he said something, he would not elaborate. He refused the offer to write in a diary, as he said he was not a writer and never had been. I noted in my diary also that his room was very bare of personal belongings, the only inviting presence was a vase of flowers which seemed
out of place. While the rooms at the hospice were newly furnished with comfortable, pastel furnishings, the sameness of each room presented a clinical picture. Without personal artifacts the room seemed lonely and clinical. It was against this background that I interviewed Mr Schmidt.

At times during the interview he displayed anger and impatience, which was not uncommon for him. Through his halting and yet matter of fact style, he presented a picture of himself in relation to his pain and cancer. I have recorded my concern in my diary, as his story unfolds. Concern is the word that first came to mind and on reflecting why this was so, I concluded it was an emotion generated by his apparent aloneness and acceptance that he had to put up with the pain. He presented as a person in control and as I listened I realised the control and acceptance of his pain emanated from his absolute belief on his God. However, my interpretation needs to be recorded as a bias that may influence the outcomes of the analysis because my education and experience has led to a belief that no matter what a person’s cultural heritage the person still has the right to be free of pain and suffering. This view I believed was in opposition to Mr Schmidt’s acceptance of pain as something to be endured.

MAGGIE PETERS
Maggie Peters was a sixty eight year old woman who had pain associated with her cancer and/or its treatment for some years. She had a long history of illness as well as being diagnosed six years ago, with a primary cancer in the neck, which had metastasised to bones in her upper thorax, right leg, and skull. Maggie was divorced and had two daughters and three grandchildren, with whom she was very close.
Maggie was admitted to the hospice, from an acute hospital, for pain and symptom control. She had been in hospital for some weeks before her admission to the hospice, where she had been for about a month before I first interviewed her. She always presented as a very bright, cheerful person, laughing a lot. She rarely complained of anything at all. She would ask for pain relief when she felt a "twinge of pain" when frequently, on further assessment, it was demonstrated that she had severe pain. She was always very grateful for even the most minor assistance.

Maggie’s room was a very busy room with many photographs, papers, letters, jars of cream and make-up, sweets and miscellaneous items, placed haphazardly wherever they would fit. One wall was covered with cards and it was often difficult to find a place to sit, as her things would spill out onto the chairs and veranda. Her long white fine hair was usually up and she always wore a soft, finely knitted bed jacket. She was often in bed or in the water chair on a veranda as she really had very little power in her legs and was not very mobile. Her phone rang frequently, and often it was difficult for the staff to have a conversation with her. Apart from her pain and leg weakness she was deaf in one ear and wore a hearing aid.

When I approached Maggie about participating in my research, she said she was delighted, as she believed research was so important. Her conversation was occasionally in the third person, as was much of the diary she kept. Maggie chose to begin the first interview with the history of her pain. She would often confuse the chronology of events, as much because of her complex history, as because of the constant interruptions of phone, staff and visitors during the interviews.
I have not commented on Maggie's story in my research notes as I have with the other participants. I have written in my diary that I said very little, and was constantly amazed by the story I was listening to. It was told with such honesty, yet in a light hearted and often humorous fashion. It seemed so incongruous, being-in-the-world of so much pain and suffering and yet to re-tell those experiences with such lightness of being. I occasionally glimpsed that I was being told something special, yet in a very ordinary way.

**JACK TAYLOR**

Jack Taylor was a fifty eight year old man and had been a builder but had not worked for over a year. He had been diagnosed with rectal cancer two and a half years before. He had undergone a large bowel resection and radiotherapy and had an ileostomy. He had been experiencing pain for the last twelve months which had been getting progressively worse. He had been an inpatient in hospital some months before the interview, in order to have the pain assessed and receive appropriate treatment. He said this was successful for about a month, after which, the pain began again.

I came to know of Jack through the home based palliative care nurse (HBPC) who had been contacted by his wife when his pain began to increase. The HBPC nurse rang me and suggested I contact Jack. She had already mentioned my study to him and she said he agreed for me to ring him and discuss it with him.

Jack’s wife Gloria initially greeted me, Jack was sitting at the dining table smoking. Gloria appeared nervous although friendly and welcoming. Jack was quiet and polite but did not initiate conversation. I soon learned from Gloria that the HBPC nurse had only been called in that week and she had
seen Jack twice. I realised both Jack and Gloria understood that my role was to advise on better pain management as well as to interview him for my research. Despite my explanations to them about my purpose they remained hopeful that I would be able to suggest more effective treatment. I also learned during the course of the interview that Jack had not been re-assessed since his pain had increased some months earlier, until the HBPC nurse saw him. I agreed to discuss his pain with the HBPC nurse, which I did, and she made some suggestions to his general practitioner and made an appointment for him to be re-assessed by his oncologist.

During the interview Jack continued to smoke and Gloria initially busied herself making tea. She requested that she stay during the interview because she was so involved with Jack’s care and she went everywhere with him, “to help interpret for him”.

Jack was willing for her to stay. I have recorded in my diary that Jack was reticent, had difficulty describing and elaborating on situations and relied heavily on Gloria to explain what he meant, although he was often short with her if he did not agree with or like what she said. I began by first asking Jack to tell me about his pain. Listening to Gloria and Jack discuss Jack’s pain was difficult to follow at times because they would not always complete a sentence or they would interrupt each other.

**BEVERLY ADAM**

Beverly Adam was a sixty six year old woman who was first diagnosed with breast cancer four years ago and underwent a mastectomy and chemotherapy in the initial stages. Since then she has had two recurrences of spinal secondaries, the last only recently, and both times treated with radiotherapy. On the more recent occasion Beverly was also diagnosed with rib secondaries and treated with radiotherapy. The pain she was
experiencing at the time of interview was in the ribs and the back. Despite treatment the pain persisted and she was taking regular analgesics.

Beverly was also seeing the nurse counsellor in the chronic pain clinic at a local hospital. This nurse recommended her to me as a participant in my study. Following the usual consent procedures, Beverly agreed to meet me for an interview at the chronic pain clinic. The lengthy interview was conducted in the nurse counsellor's office; she was present at Beverly's request, but took no part. The office was familiar to Beverly and she felt very comfortable with the counsellor.

On meeting Beverly, she appeared calm and friendly. She was quite happy to be interviewed and she also offered to keep a diary, which she did, for a period of two weeks. However, during this period her pain was minimal and she recorded only the length of time she had an episode of pain and what she did to relieve it. She wrote “the pain has not been a concern for me”.

Beverly lived with her husband, Tom, had two married children and three grandchildren. She acknowledged that she had a close relationship with them.

THE CIRCULAR PROCESS: AN INTRODUCTION TO THE ANALYSIS

Much of Heidegger's work in Being and Time (1926/1962) follows a circular path based on the forestructure of understanding, and includes everyday dimensions of Dasein that project towards the existential possibilities to determine the meaning of Being. The circular pattern is
fundamental to Heidegger’s philosophy and has been adopted in this study, not just in the exploration of reaching an understanding of knowing cancer pain, but also in the presentation of that process.

Exploration of ways of knowing cancer pain began at the point of data collection, which Heidegger cautions as being important to the whole project, “what is decisive is not to get out of the circle but to come into it in the right way” (1962, p. 195). In keeping with Heidegger’s version of the hermeneutic circle, it was necessary to elicit the ontic dimensions of being, initially, through which the ontological dimensions were uncovered. This was Heidegger’s project; to understand the meaning of Being, using *Dasein* as the vehicle. My project was to apply this method in order to understand the meaning of knowing cancer pain as a mode of Being. Kaelin, on reflecting on the circularity of understanding, warns that,

We must remember that understanding is a way for a human being to be; and that our being exhibits a structure that is itself circular... Care is circular, the call of conscience is circular; and in projecting an explanation of these phenomena ... our understanding is likewise circular (Kaelin, 1988, p. 192).

The text from each patient was analysed within the framework identified in chapter four. In addition, it was fundamentally placed within a hermeneutic reflective framework to allow full advantage of Heideggarian philosophy to influence the outcomes (Walters, 1992). Continuing the decision trail, it was important to define the relationship between the areas identified as the
links in the framework, namely, *Dasein*, understanding, knowing and the self; and the resulting themes.

**THEMES**

Heidegger is concerned with meaning, and in the process of discovery, meaning became multidimensional requiring a method of analysis in keeping with the underlying philosophical framework (van Manen, 1990; Sandelowski, 1995). In this context, "theme analysis’ refers then to the process of recovering the theme or themes that are embodied and dramatised in the evolving meanings and imagery of the work" (van Manen, 1990, p. 78). Heidegger (1926/1962) identified experience as the means to uncovering Being, and so I have used the process of thematic analysis to collate the structures of experience that have an underlying common meaning, from individual text, as I interpreted it. It is this interpretation that Walters (1992) refers to when he speaks of hermeneutic reflection and van Manen (1990) refers to as a “process of insightful invention, discovery or disclosure” (1990, p.79). In analysing and presenting the data, I have adopted Dreyfus’ (1987) interpretation that the communal person reflects the common background upon which Being and therefore, understanding, is made known and the individual person is an extension of that. This view is in part supported by the relevance of the individual to Heidegger’s phenomenology by other Heideggarian scholars discussed in chapter three. The individual aspects of knowing pain will be discussed in chapter six as they relate to the area of pain assessment.

By applying the analysis to the ontological dimensions, which Heidegger described and whose relevance is discussed in chapters, three and four, the circle is completed. The ontological structures are the understandings of
everyday existence and the themes uncovered are the ways of knowing pain for these participants. The themes have been developed from the ways in which the participants managed the competing and sometimes conflicting issues, demands and situations that confronted them, because of their pain and the limitations that the pain caused. The differences between the participants in relation to the components of each theme had to do with the physical differences they were experiencing and the meaning in their lives that particular issues held for them. However, these differences are set against a background of common understandings, and will be elaborated below.

The themes that recognise the Heideggarian application to nursing and uncover ways of knowing cancer pain are: balancing conflict, living with threat, always there, and making sense. They will be discussed below and have been identified by first isolating the more concrete entities that have contributed to their commonality through identifying sub-themes. These themes and sub-themes are illustrated in Table 1.
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<td>Making Sense of Pain</td>
<td>Believing</td>
<td>Being Positive</td>
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Table 1: Themes and Sub-themes

**Balancing Conflict**

The theme of balancing conflict was not a planned pain management strategy but rather an inherent way of coping, consistent with Heidegger’s notions of *Dasein* and understanding and knowing. The notion of balancing is important because it identifies the inherent conflicts that were part of living with cancer pain for these six participants. The factors that contributed to this emergent theme are: balancing pain and medication; balancing pain and response; balancing independence and dependence; balancing self realisation and others’ perceptions; being strong/being frustrated. These sub-themes will be discussed below.
Balancing Pain and Medication

The relationship between pain and medication was an issue for Ida from the beginning when she was first diagnosed, knowing that you’re not going to get any better and you’ve got to be on the medication all the time for pain, it’s really devastating. She has tried to balance this since, taking medication only when she needed it and not always agreeing with the staff, ...they want to give you something for the pain and I don’t think that is necessary with me all the time. I don’t like those tablets. Constipation was a consistent problem for Ida, but one for which she was always looking for a remedy, hence many of the jars on her locker contain herbal treatments for constipation. She also endeavoured to balance the effects of the medication on her bowel and pain relief, it might help with my bowel if I don’t take all this medication, I’m trying to eat more too – it has to be a balance with the pain, the medication and the bowels.

The routine of pain and medication required a sense of balancing the two, in Veronica’s struggle to get rid of the pain.

It would be good if I can get off all these things (syringe drivers). They’re rather cumbersome. I don’t even like taking pills and things because they all have side effects of some sort. It’s a vicious circle, you take a pill for something and it gives you something else, and then you have to take a pill to relieve the symptoms of that. One makes you constipated and you have to take coloxyl. It’s a vicious circle you end up with more and more pills all the time ... I don’t like it but its necessary if I
want to get rid of the pain although I am careful with my diet and I sleep when I need to.

Balancing Pain and Response
In the conversations with Ida, she talks about the excruciating pain and at other times she says the pain is nothing and talks about, (I) try not to complain when it wasn't so bad. She is describing different levels of pain and with each level she balances the most appropriate response. With the excruciating pain she screams out and with the less severe pain she makes a milo, takes a tablet and either goes to bed or continues on with what she is doing. Although screaming out is not like her and she feels the need to justify the severity of the pain by invoking her neighbour’s recollections of its severity, she knows this is what she must do when presented with it, although she says, I can’t explain it really – why I do it – it is a relief.

Mr Schmidt has learned to balance his pain against the need to maintain control. Balancing the conflicting parts of his life with his understanding of the need for control eliminated any uncertainties from his life.

You don’t run around and go and see the doctor and get some pain killers and go to hospital, try to keep it under control the best way you can. That’s the same as me you know that helps me a hell of a lot and keep it under control. You do, you do find ways of dealing with it yourself, and well first of all you accept the situation as it is, that’s all, it is once you accept it, there you are. It is a way of life, if you are a Christian then you live a certain way. You, you see
things in a different picture than somebody else see.
Somebody else say, why prostrate cancer why me. I don't say that.

He talks about waking at night having to massage his leg so he can get some more sleep, and he is constantly changing positions to relieve the pain. He has no mechanism for seeing other options - he expects to have pain all the time and he will not tell the staff about his pain, there is no need to tell about the pain, they are all well aware of it, the people around me.

The relationship between Maggie's pain and her response was a primary factor in her life. Originally her efforts were directed to overcoming her disease as well as the pain, however this changed, as her condition deteriorated, to one of balancing the pain and the effort required to control it.

Just whether the pain was getting better or worse and that it was all connected to the cancer and I was just feeling it too much or not dealing with it in a satisfactory way. There must be another way - dealing with the pain reducing its impact on my body that I haven't found, it's too important for me to put my efforts into meditation and try to do my part to get the balance which the doctors are able to get medically.

Balancing Independence and Dependence
Ida endeavoured to retain as much independence as possible, which was obvious to the staff soon after she arrived at the Hospice. I have recorded in
my diary notes from the understandings I had about Ida when caring for her; she would take herself off to the shower and the toilet without telling the staff. The nurses had frequently asked her to allow one of them to assist her because they were concerned about her falling. However, she said to me that if she fell, she fell and that it would be better than having someone help her all the time. Anyway, she believed in her competence to look after herself and she was very strong in enforcing that belief becoming ‘devious’ in slipping out of her room undetected.

Veronica describes different levels of pain, which she balances with her need for independent activity.

*The ordinary pain you just learn to cope with it you just take it as part of living, but when it comes to the serious pain I don’t know what happens then about how to cope with it, because it is very hard to cope with it. The ordinary pain you just learn to take it as it comes and cope with it. With the really bad pain I am unable to do anything except lay on the bed and call for help, …. With the lesser, more bearable pain I’m able to walk around with the aid of walking sticks, and do minor household tasks, and things around the home. I organise my jobs and my time so it doesn’t cause me any problems – small amounts at a time so I don’t overdo it.*

In striving for a level of independence, Veronica has to make adjustments and changes in striking a balance between her pain and her independent activity.
I would get up in the morning and I would make the beds and wash the dishes and have some breakfast and then I would feel quite exhausted so I would lay down for a while and then I would go for a walk around the garden, and “I’m starting to try and organise things. I’m fairly isolated up here because the neighbours are all nice but are out at work so I’ve started going to the cancer support group again now.

She also realised there needed to be a balance between what she could do and what she needed others to do in order to have a level of independence.

Friends take me shopping so I handle my own money and I’m finding out about what type of help and assistance there is and I told a neighbour down the street, …. I was on my own for three days and if she didn’t see me around to check up, because if I fell in the garden nobody would know.

This kind of co-operative functioning is seen in her relationship with her daughter.

She’s good …. cooking the evening meal …. ‘cause I’d sleep in the afternoon and do the vacuuming and clean the house. I’d do the washing ‘cause the washing machine does that, but she’d carry it down
the steps and I’d hang it out she’s been doing the
bulk of the work.

It is the simple taken for granted activities that have meaning for
Veronica, and that reflect her level of independence.

My friend Jane took me shopping one day, that was
just a week before we came in here and we went
down to Woolworth’s and I did my own shopping, so
I felt a little bit more independent for the day.

Jack’s demeanour, lack of animation, diminished hope for the future and his
acceptance of his situation reinforces his own words, you get depressed by
it. He is anchored in the present experience of pain, which he says is a
physical assault. Listening to him he seemed to be dependent on what was
happening to him. Some ambivalence is uncovered when he is able to
glimpse some future, oh, I hope they do – get rid of it completely. I’d like to
get good sleep. Other glimpses of hope are uncovered in his effort to
understand his pain with the pain chart, and his effort to play golf, it was
bloody hard, but I made it. Jack initiated mention of the changes he has
experienced since he has had pain. He discusses these in his halting and
abbreviated style.

I doze off, like if you weren’t here now, I’d be
reading and dozing off. Yeah! It wares me down. Its
frustrating – it stops you from doing things like me
social life a fair bit. I used to play a fair bit of golf;
I miss that although I still play a little. I played
yesterday; I have a little cart I go around in, I can’t
walk very far. I cross the road here and I'm bugged. It was bloody hard but I made it, even won a ball yesterday. I miss me social life you know – go and have a beer with the boys. I still go and have a yarn to them but can’t stay for very long.

Balancing Self Realisation and Others’ Perceptions
Maggie would also find ways of balancing what was happening within her and what others perceived.

It was a natural progression for me to do this but still I was hampered by the slur of inebriation which gave me a bad time .... socially one is – one carries a stigma and this is well documented. I was dismissed as being just an odd job, but the stigma still goes and it is a matter of amusement and that sort of thing for other people and one of the things I had to do was disassociate my life from the activity I was forced to use. By that I mean go shopping whether I staggered or I didn’t and so I forgot about that and said to myself that if people wanted to be amused or sympathise that was their problem, and that was the only way that I could deal with it and do my necessary actions involved in home and family.
The changes in Beverly’s life since her diagnosis and the advent of her pain are many. She has to balance the day to day activities, her understanding of what is happening and the perceptions of others.

*It stops me doing things around the house. I know what I have and how to manage it but the word cancer to some people has a stigma. I had a very dear friend and she still cannot say cancer, it’s the big C to her and she still cannot talk about it with me.*

Jack’s own perceptions and difficulties dealing with his pain in particular are compounded by the perception of others. Gloria describes the situation where his best friend would not come past the door, to which Jack responds in a subdued manner, made more meaningful by his brevity, *said he wasn’t going to come in*, as he sat, head bowed and shaking. Gloria explained that this was a regular occurrence until his friend stopped coming and almost defiantly Jack added,

*I need to be aware that there are still some people who cannot talk about cancer, that it makes them very uneasy to talk about cancer and to see someone in pain, and to be able to cope with that type of person, because that’s the way they deal with it and not everyone deals with it the same way.*
Being Strong/Being Frustrated
Ways of knowing pain are sometimes ambivalent for Jack. Pain is present
to Jack by its physical hurting, its relentlessness and by the ambivalence it
provokes. Gloria describes Jack as being strong, he’s a strong person
anyway - he’s always been a strong person. Jack, however, is not sure, I
don’t know myself that well... people tell me that, but I don’t know, although
he says his strength is holding out at the moment, I’m so tired and dopey
you know, but I’m strong enough to cope with it at the moment. At times his
strength is replaced by the weakening effects of frustration that he has in the
face of the relentlessness of his pain and not being able to overcome it.
Yeah! It wears me down. I doze off. Yeah! It wears me down. Its
frustrating – it stops you from doing things.

Jack is also faced with the loneliness of his pain and his inability to convey
his experience to others. This situation is a source of frustration for him
also.

It’s bloody frustrating – you can’t explain it. Unless
they’ve suffered it themselves they don’t know, they
say ‘know how you feel’, they have no idea how you
feel.

Because of his experiences of pain, Jack is isolated from others because they
are unable to share the experiences, and Jack is unable to convey it.

Maggie describes situations in which she knew what was happening inside
her body, and despite her conveying this, her intimate knowing was not
acknowledged. She had to balance a situation that was a threat to her life,
and that she found frustrating, against her own strength to deal with it, because she could not find a way to change it.

Maggie related the story of when she was diagnosed with cancer.

I was very calm and collected actually when they finally decided it was cancer, because I had believed for a long time, I mean years, that I did have cancer. No-one has ever said so, but I just presumed that. I put down then a response to the MS [multiple sclerosis] but also that it could be at the back of my mind a result of the weakness that I presumed was going on in my body that was due to the cancer which I believed all the time that I did have ... I told them at the time, what I thought. They said nothing, they were quite unflappable, but they did reiterate to me that they thought it was not cancer, they thought it was just a lump. You just have to be strong because there’s nothing you can do to change their minds.

**Living with Threat**

Living with threat refers to a way of knowing pain that directly or indirectly impinges on everyday activities of life. The threat may be implied or impending and suggests that an undesirable harm will be the outcome. The sub-themes that contribute to the theme of living with threat have been identified as: not knowing; pain taking over self; maintaining control; and overcoming threat. These sub-themes indicate that part of living with threat
was not only the threat itself to self and normal ways of coping, but also the responses to the threat.

**Not Knowing**
Ida’s way of life was filled with not knowing what would happen to her, and included the pain itself and her future. Not knowing for Ida was perceived as a threat to her being because it challenged the life she had established for herself and which had meaning for her.

From the time Ida first experienced the pain she experienced uncertainty and did not know what was causing the pain and so related it to what she did know; the pain she used to have, *not knowing why I had the pain was the thing. It was just relating it to what I did know.* This situation became more uncertain for her when the pain continued and she was diagnosed with cancer. She did not know what would happen to her and where she would end up living. Her story reveals her concern that she would have to go into a nursing home.

> I like to do things for myself ..... I knew I that I'd have to give up my home and that hurt me more than anything really, to give up my few shackles and things .... I was more worried about going into a nursing home than anything else, and to leave my home. I didn't realise, well I did know all the things I've got, but you sought of get very tired trying to sort it all out.
Veronica was very uncertain about her future and unsure how she would continue to manage at home, causing her to live her life with the threat of not knowing how she would continue to live her life as she wanted.

*I felt quite frightened, you are at home with no help and it was an awful experience and very severe. More an agonising pain with the leg. I was always a little bit frightened because I think it can get worse and I might end up back in the hospital and the hospice again. I was concerned and unsure about [the future] because if I get worse would I be able to manage at home? You think of nursing homes and such which I would hate and I think what would happen to my animals and things like that.

Even Beverly with her positive outlook, has moments of uncertainty about whether her bouts of pain mean further physical deterioration. Although Beverly indicates she is concerned about making the most of the present, she also understands the possibilities for the future and how her present situation can influence those possibilities. Her pain projects her into the possibility of the cancer progressing.

*I think is this another one. I will immediately think is that in a different area or is that in the same place and think about it to make sure it is in the same area.
Pain Taking Over Self
Pain as a threat to Veronica’s being is demonstrated a number of times throughout the interviews and she also made reference to it in her diary. The physical hurting, at the most severe level, presented a threat to Veronica’s life and her person, creating a sense of helplessness and, therefore, she wanted it to stop and to get rid of it. *Your mind and every part of you just concentrates on that pain and how to get rid of it, your whole being is focused on that pain, it’s excruciating that pain – it’s really bad.* She sees the pain as an entity that is taking over her person.

*You just want to get rid of it you just want it to stop. It takes over everything you do. It’s going to take over my whole life and its not going to get better. This pain just completely takes over, it just takes over, it just comes out of the blue as if someone’s grabbed hold of you and is really hurting.*

The pain is a threat to her existence, of which the core aspects are control and independence. This threat to her existence is again demonstrated when Veronica talks about the time her cancer was diagnosed, *I wanted to get rid of it because I felt I had more chance to survive.* She again reinforces the fact that it can take over her life.

*I was worried that its going to get worse and that it’s going to take over my whole life and its not going to get better. The pain is excruciating it is really really bad. You don’t feel as though you have control over it. With the severe pain it is agonising all you can think about is the pain and how you can*
stop it because the pain in my leg is very severe and the last time I came into hospital I had to call my daughter. I couldn’t even make a phone call ‘cause I was in so much pain and its very frightening and it’s just a horrible feeling being in so much pain. I called my daughter to help me out and all I could think was getting a doctor or getting some sort of medical help it is a frightening experience. I dread the thought of it because it’s such a severe pain, it’s not nice at all. I worry about it coming back .... I think, here we go again (laughs). You just have to experience it to really know what it is really like, its not like an ordinary headache or cutting your finger or like that it’s a really severe agonising pain, it just stops you doing everything and you just concentrate on it. Your mind and every part of you just concentrate on that pain and how to get rid of it. Your whole being is focused on that pain, it’s excruciating that pain. It’s really bad. Well I suppose you are frightened because when I was at home you’ve got no one.

The pain threatened Jack in a way that he describes as an assault.

I get up and come out here, have a couple of smokes and some elixir. The worst thing is I can’t sleep and it’s bloody painful ... And the physical assault. Yeah! It’s an assault ... it gets me down, especially at night time, up all night.
Evidence that the pain was taking over was uncovered in other ways that left Jack without strategies to deal with the situations as they arose. He did not communicate his pain to his general practitioner or to the oncology nurses he saw every week when he received his chemotherapy. Gloria explains, with which he agrees, ... *he was going to the GP but he didn’t say he was getting the pain at night. It makes it hard doesn’t it?*

Jack has times of being alienated by the overpowering nature of his situation, either of his own making, ... *if I have visitors and I’m tired I just go into the bedroom. Sometimes you don’t like having visitors, you know all sympathy type of thing – you can’t explain to them.*

Jack’s pain was also overpowering for him because he did not have past experiences from which to draw. *I don’t know myself that well, people tell me that, but I don’t know, I don’t think I’m any stronger than anyone else.* He was not used to going to the doctor, and by implication not used to being sick. Gloria describes the situation,

*He’s so accepting, you wouldn’t believe it (Jack nodding agreement) because he couldn’t stand sickness at any time or anyone with any sickness and now he is ... he’s done his narna all his life and now he’s sort of so calm like a little kitten.*

Gloria described Jack as strong and always able to fix things. He could not fix his pain, *well what do you do, you can’t do much about it.*
Jack initially attempted to deal with his pain by doing what he knew best, and so he would work in the garage when he had pain. He would work through it as Gloria said, but as the pain increased, he became worn down, just sick and tired of the bloody thing ... it does wear you down. Now he spends very little time in the garage.

There is very little reference to the future or to other possibilities that can be seen by Jack or Gloria. Jack’s pain is such a threat to him that he cannot see beyond it. It has immobilised him. When he saw his doctor he didn’t say he was getting the pain at night. Gloria understands the difficulty.

It makes it hard doesn’t it, because you don’t know what you are supposed to tell him [GP]. I mean he’s not one to go to a doctor so I mean he’s not going to tell him too much.

Jack was nodding agreement and repeating yes, yes. I can’t understand what he says anyway. He mumbles. I later found out that the times he saw his GP he did not have pain, and so when he was asked if he had pain Jack would say no, because he did not have any at that time.

**Maintaining Control**

Veronica’s existence is entwined with her sense of control over her life. She makes reference to this in her diary and reinforces the continuity of the control the pain has, the resulting helplessness and its threat to her independence.

*With the agonising pain it takes over completely and I felt very frightened and helpless being at home*
with no medical help. You don't feel as though you have control over it. I feel like I've completely lost control of my life because other people are doing it and I don't want to do that, I want control of my life again.

The pain threatens Veronica’s existence when she loses her sense of control and independence.

When the pain is less severe, Veronica shows she is not as threatened and is able to rise above it, regain control and get on with her struggle to regain her independence.

When it's the mild pain I can do things to a certain extent, I don't feel useless, but when its the really bad pain I feel completely helpless and just hobbled down the street and back, quite painful walking. Pain is always there but I can live with it these days.

After I last saw her, Veronica’s struggle continued for some months until she died. I have recorded in my diary that she once mentioned to me that her pain was not visible to other people, and therefore others expected more of her. She refers to this also, in her diary, because the pain is not visible and I look normal and healthy she (her daughter) seems to think I can do things normally as I used to. I believe she also expected much of herself.

Mr Schmidt’s pain has been a threat to him, either to his integrity by being labelled a malingerer, or to his mobility, which he sees as the worst part of
the pain/cancer. He always understood that his pain could not be shared, an understanding where he was alone in his suffering. He has brought that understanding to the current situation.

_I never wished a life where I was constantly and permanently out of pain I always had something or other. Forty years back they would have called me a malingerer and, as long as I was under 65 of course, after that I could go to the doctor and say I am sick, I have pain I can’t work and the doctor will say, you don’t have to work you are on the aged pension in any case, and if I come and say I’m in pain and I can’t work he will say anybody can come and say I’m in pain I can’t work I can’t establish whether you’re in pain or not, you just want to go and live on social service. He seems almost relieved to be able to say, now my legs look sick, but that wasn’t before, when I first got the pain. See I have swelling in the legs now but they don’t look bad before and my legs are weak and I can’t walk too good now._

The pain now is not so much a threat to his integrity because it is more visible and the perceptions of others are more controllable. For Mr Schmidt, the pain threatens his mobility, but he controls this threat with his acceptance, _I just have to live it out whatever comes_. It is a threat to him because of its inevitability and its effect on his mobility.
The worst is you can’t get rid of it, it, it’ll come back sooner or later, and it doesn’t get all that severe, but it immobilises you that is the problem. It is the effect of the pain rather than the pain itself.

The important changes to Beverly’s life revolved around her family and what she could and could not do with them, because of the pain.

I want to do things with them as long as I can. I made that quite clear to them and the fear at the moment is that I can do things with my older grandchildren, they’re four and six, but I can’t nurse my baby granddaughter. And that upsets me because it’s holding her across the ribs and that’s where the pain is.

Her acceptance and way of managing the changes and expectations are active in that she attempts to have some control over events.

I just learn to cope with it on a daily basis and find out your own strategies for dealing with it. There’s no point in complaining about it because complaining is not going to do anything about it ... the cancer, the fact that it is there, that I don’t know how long I’ve got and I don’t want to know how long I’ve got, but to make the most of the time I’ve got.
Overcoming Threat

Overcoming adversity was a way of living for Maggie. Her history of relying on her own resources has been a natural response.

So many doors were closed I suppose it's because it's been so long, one becomes conditioned to rely on oneself and this is what's happened. I'm experimenting all the time with ways of dealing with it, on the basis that it (pain) might increase and then I must address the situation now in case this does happen, so I'll be prepared.

Maggie’s pain and her long history of illness were a threat to overcome,

I have had a lot of illness and a lot of pain to put up with without any domestic or family help. As the doctors dismissed all situations the family dismissed them too, I was in a corner and all I had to depend on were my own resources.

Maggie’s instinctive response of using physical exercise to overcome a problems with her body is evident.

I have been interested in strengthening my muscles since I was a teenager and got carried away with body muscle improvement, and strengthening and caring for the body in general ... so it suited me to do this because I always did it anyway ... I also think it will help the pain as well as the weakness.
Jack and Gloria have identified one way in which they have become stronger against the threat of the cancer and the pain.

*We started talking a lot more and a lot more openly with each other and we've always been very close to each other and we've always communicated well, but we've communicated on a different level since I've had the cancer and been more open about our thoughts on the cancer, where it can lead and that sort of thing, and to be able to live with the pain I have, I need to be patient to accept each day as it comes.*

**Always There**

The theme, always there, refers to those entities that were always present to the participants, even in their absence, and influenced thoughts, feelings and behaviour. This theme is comprised of the sub-themes: pain and cancer; worry; and being aware of mortality.

**Pain and Cancer**

The pain and cancer were always present to Ida even though they were not always physically with her. The pain was always present to her in the medications, the constipation and the nuisance of taking medication regularly. The cancer was always present in the pain, the contribution to functional bowel problems and the slow deterioration that Ida experienced. They were always with her and influenced her way of knowing her pain.
Reflecting on her past, Veronica revealed that her independence has always been part of her existence which gives credence to the constancy of her struggle.

*I’ve always been independent, I’ve always had to do things for myself since I left home, even when I was married my husband didn’t do a lot so I used to sort of manage things... Probably that has helped me now because I’ve always had to cope and do things for myself.*

The pain Veronica experienced was always with her through the currency of its challenge to her life, the worry, fear and glimmers of hope. The most fundamental constant is uncovered when Veronica spoke of *the pain and the cancer – it’s the same thing because the cancer is the cause of the pain but I might be able to beat it yet.* The constancy of the struggle to maintain her self against the threat to be overtaken becomes clear.

*I’ve got to work out things to help myself to be independent because I can’t expect Angela (daughter) to help me all the time,*

And as the pain began to improve;

*I’m finding ways of doing things for myself now and I am always looking for ways.*

Her constant struggle is a reminder of the pain even in its absence.
Mr Schmidt acknowledges that he has always been the same in his approach to life, especially in relation to his pain. His acceptance and control have always been part of his life.

*I've always lived like that. Of course you wouldn't find a man or a person who just because of that, changes his way of life, you can't do that from one minute to the other, that's not on that's how I take care of it (the pain).*

Beverly’s pain is her cancer and her cancer is her pain. While the cause and effect nature of their relationship is obvious, for Beverly this relationship does not exist. They are both one and are part of her life. Whenever she gets pain it makes her think of the cancer.

*When you get the pain it makes you aware it's the cancer, probably when I haven't got the pain I don't think about it as much but once the pain is there it makes me more aware of the cancer.*

It is more fundamental than one causing her to think about the other. When Beverly began speaking about her pain, she would automatically refer to her cancer or its effects on her life.

*Possibly my expectations have got less since this last bout (of pain), but I'll still think that so many years time that you'll be doing this or so many years time Janie (granddaughter) will be going to school and I'll be seeing her in her school uniform and different*
things like that I think you gauge it more by my
grandchildren really as much as anything.

The pain/cancer relationship influences the way Beverly responds to an
episode of pain.

Each time I haven’t thought immediately about the
cancer as causing the pain but I think now after this
one I’ll be more aware that its more likely to be the
cancer and that’s why I say this one’s made me
more aware of it. I’ve just got to work it through
and the pain has just got to work itself through.
Whereas if I’m not thinking about the cancer or if
I’m in a positive frame of mind then I can
immediately start working lets get on with this.

Worry
Worry and fear are constant companions that envelop every other aspect
of life. The presence of the pain is a constant worry for Veronica.

It’s just like something that grabs me and doesn’t
want to let me go, and pain stops me from walking,
something I’ve always taken for granted. Every time
you get pain you think that it is getting worse which
is always a bit of a worry, ... its a constant worry.
Veronica writes, the fear that it will progressively
get worse so my whole life becomes unbearable.
Feel slightly apprehensive in case the pain comes
back, I worry about it coming back ... I think, here
we go again and, then I’m worried that it’s going be
— that I’m going to be in constant pain all the time.
Each time it happens it gets a little bit worse. I was
always a little bit frightened because I think it can
get worse and I might end up back in the hospital
and the hospice again. Also if the pain gets worse
and you can’t do anything about it, because each
time it happens it gets a little bit worse and one
vertebrae has just about disintegrated and causes all
the trouble and I’ve got more now about three or
four that are all bad. It’s a constant worry though,
because I know my condition is not getting any
better. I always had a very positive attitude though
because I’m also very realistic about it and I know
that it’s not going to improve. Then I’m worried
that it’s going be – that I’m going to be in constant
pain all the time. Since I’ve been in here I’ve
realised there’s a lot that can be done to help the
pain.

Being Aware of Mortality
The combination of the nature of the cancer, Ida’s age, and the adverse
effects of intervention, conspired to make Ida’s death inevitable in the near
future. Whatever she did, wherever she went, the possibility of nearing her
death was constantly present to Ida.

Please God that I won’t last that long because I
know I can’t get better and they’re keeping me so
comfortable. I feel it's only prolonging the agony for the ones you're leaving behind.

Ida knew of her impending death and how this was impacting on her life – the relationships she had and the way she saw the world, I'd rather have my life taken now before it got any worse. Ida described her resolve in the face of her death and the transition in the relationship this caused with her son, when she tried unsuccessfully to discuss the funeral arrangements with him.

He just looks at me dumbfounded and I didn't shed a tear, but I think he could have sat down and had a darn good cry but he wouldn't talk about it.

Pain is present to Beverly as her own mortality, which she recognises has positive possibilities and a heightened awareness of life and living. I have written in my diary that she seems very comfortable speaking about her mortality and conveyed a sense of having given it much thought.

The pain makes me feel mortal – what I've missed out on, on doing with my family and that it's made me family orientated that I'm thinking of as far as missing out on doing things with them. But it also makes you appreciate your life as we have it, and the pain – it's the important part of it all, but that sounds stupid doesn't it? I think it keeps you aware that there is something going on in your life that is life threatening so therefore make the most of what you've got now.
Beverly often alludes to this view of her mortality throughout the conversation. Her sense of mortality is grounded in being-with her family. Knowing this drives her hopes for the future.

_The fact that I want to survive to see my grandchildren grow up. Things I want to do with my husband and the family ... that so many years time that you’ll be doing this or so many years time Janie (granddaughter) will be going to school and I’ll be seeing her in her school uniform and different things like that._

**Making Sense of Pain**

Making sense as a theme has emerged as a way of coping with the pain and cancer. It is a way of knowing pain that attempted to make living with pain more bearable. The sub-themes that constitute making sense as a theme are: believing and being positive.

**Believing**

With the onset of pain came enormous changes to Ida’s life, so that the world she knew became a world of pain, medication, physical and social restrictions. She changed physically creating a change in her level of independence, necessitating the loss of her home and all the things that living there meant for her. Ida drew on her longstanding faith in God to derive meaning of the changes to her life. This became obvious when she talked about God having a hand in things and Him giving her strength. Ida frequently referred to God and how He has helped her. She referred to Him at the times she feels at risk of something she cannot control.
Knowing that you’re not going to get any better and you’ve got to be on the medication all the time for the pain, it’s really devastating. I just can’t believe it’s happening not only to me but to all the people that are suffering but I’m sitting here getting AI care. I sought of think well how lucky I am and yet where’s it getting me? I didn’t even think of cancer at the moment, it was really unreal the way I seemed to accept it you know. I feel that when I came here that the atmosphere of the place seemed to change me too, I could feel God sort of round and near me, and I really feel God’s had a hand in that, God gave me the strength. I am quite happy as I am going and I feel God has been good, he has taken this pain away and I didn’t expect it to be taken away like this really, because it was excruciating when I’ve had it.

Maggie believed that she had cancer for quite a long time and because no-one else believed this, Maggie had to accommodate this belief in the way she lived her life and made sense of what was happening to her.

The doctors didn’t believe the lump was anything to begin with. That was dismissed with a shrug, as nothing, for years and years, so what could I do, I couldn’t take it out myself. And it all started from there really, except the injury to the lumbar spine, and that probably muddied the waters, fact of arthritis is there also...I don’t know it certainly
didn’t respond to ... I take that back ... it did respond in a way to the anti-inflammatories which also set up its own side effects and caused problems there so that was not a success. I went from GP to GP and none would take it out until I found one who would and then it was quick, quick into hospital but it was really too late by then.

She was not bitter about this but developed strategies to deal with it, such as exercise and mental strength.

Maggie’s long history as she describes it is about a person who had many struggles with medical and non-medical people around her, as well as with the pain and disease itself, both of which were potentially sources of anger and resentment. However, again she came to know her pain through the effort to overcome these emotions and her belief in herself.

I’ve always tried to overcome those emotions, they are a hindrance to dealing with the pain and to getting well, of making a whole disease worse instead of better, not to batter the disease with anger and resentment, but to overcome the disease and pain, overcoming the pain with mental attitude and work.

When I was caring for Maggie, she said to me that she had taken steps to overcome the pain and fear within her marriage. She would not elaborate and became evasive and so until I read her diary, this comment remained unclear. Whether or not Maggie saw that the suffering within her
marriage related to her cancer and pain is not clear, although the fact that she wrote about it in her diary in which recorded episodes of her current pain, raises questions about the perceived connection.

Mr Schmidt also believed that the pain he has experienced throughout his life has a connection with his current pain and cancer.

Since I was in early twenties I had back pain and this what I had now was a development from that back pain. That is what I believe, I can’t prove or anything. I reckon that cancer business has been in my body for as long as I remember. I wouldn’t know how long I had that cancer but it was detected 2 years back. It was established long before that. I think it goes hand in hand you know, the seed for the prostate cancer was there but it didn’t blow up, that’s the way I feel about it.

This perspective helped him to make some sense of what happened to him and why and provides certainty in his life.

In the past he struggled to deal with the pain himself, so as not to be seen as a malingerer. This sense of how he should manage his pain changed because being a malingerer no longer had any meaning for him although his mental abilities did.

I have memories of having really bad pain... I tried to prevent those situations naturally, it was more during my working days that I had those pains. See
in the olden days, I used to force me to go to work and then you get those situations where you get real bad pain. I'm not forced in those situations anymore at work. I have to walk with the walking frame, it does not affect my mind or emotions, I am only physically affected not mentally.

Mr Schmidt relied on his religious beliefs to make sense of what is happening to him.

I live for what's now not for the past or the future, what I say is whatever the future holds for me is laid out for me and I accept that. I got no qualms about that and it is the best for me because nothing bad comes from God. It is a big help.

It can be seen from Jack's conversation that he made an attempt to regain some ground against the threat of his pain by making sense of what was happening, in a way that he was familiar with – making something.

When he first started to get the pain he would go to his shed and make some things out of wood. He was better when he was doing that. [Gloria]. I could think out there.

He also initiated a pain chart because, it just shows how things are. Gloria added that his pain became more concrete when he could see it, and perhaps not so threatening. He was also trying to make sense of the medical world by categorising the doctors and working out his best options between his
GP, the HBPCN and the specialist, my GP doesn’t seem to know much ... he goes along with what Mary [nurse] tells him and these cancer blokes use the treatments every day.

Beverly finds meaning and comfort also from her religious beliefs and her family.

The cancer, the fact that it is there, that I don’t know how long I’ve got and I don’t want to know how long I’ve got, but to make the most of the time I’ve got. Not that I think I’m going to go tomorrow or next year or anything. Believing in God helps me. I know that when I do go, I’m going to a better world, not that I’m in a hurry to get to this better world, (laughs) there’s a lot of things I want to do here first. What the future’s got for me.... the fact that I want to survive to see my grandchildren grow up. Things I want to do with my husband and the family, that I may not. Probably what the future, what is in the future and how I’m going to cope with it - more pain and what the cancer’s going to do ... but I’ll still think that so many years time that you’ll be doing this or so many years time Janie (granddaughter) will be going to school and I’ll be seeing her in her school uniform and different things like that helps me to cope with it all and look forward.
Being Positive
I have recorded in my diary that having witnessed Veronica’s struggle to
overcome the debilitating effects of her pain, I felt in awe of her
determination to regain her independence. When I saw her at home I
asked her how she did this and she responded by saying:

*Wanting to do it ... I feel that I am positive about it I
have a better chance. I’ve seen people that have had
cancer they just give up and they die, so I think its
something you have to fight and be positive about it
... I think you’ve got a better chance then.*

Her struggle is supported by her hope;

*It happened to me three years ago .... there’s always
a chance that this will work again.*

Being positive was a way of life that has underpinned much of Maggie’s
knowing her pain. She spoke of her instinctive feelings to get rid of
negative emotions so she could focus on positive and constructive aspects of
managing her pain. Being positive stayed with her and allowed her to move
on to deal with the next threat to her and not to be left with the *what ifs?*
Referring to her reduction of her medication when the arthritis was
diagnosed, *...if it is as important as it would appear to be, then I have work
to try and get over this hurdle of pain, through which I’m going now.* Being
positive is part of taking responsibility for herself.

*But pain, I might add is accompanied by weakness
in the limbs and a general deterioration of the body*
which is applicable to the cancer itself, so I obviously haven’t dealt with this properly, nor I have I come to a satisfactory conclusion in conquering the area of pain, but I’m working on it.

Maggie constantly looked to herself for the strength to manage.

Just how I can deal with it and when I show how I can deal with it whether to lean on that leg just a little bit or push the pain into the leg - I’m experimenting all the time with ways of dealing with it, on the basis that it might increase and then I must address the situation now in case this does happen, so I’ll be prepared. I suppose it’s because it’s been so long, one becomes conditioned to rely on oneself and this is what’s happened. I don’t mean no one has helped me - that’s not right. My specialist has done everything she possibly can to see what can be done and to point me in any direction she might think will help. And again, here I feel I am getting all the help available but its up to me to augment this help and see what I can do for myself that’s what I’ve always done.

Even when she was weakened emotionally and physically, just prior to her death, Maggie always attempted humour. Humour was her trademark which always seemed genuine to me, and which seemed to be a place of respite for her. When I told her this is how it appeared she laughed and said that could

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be right as it was a great salvation for her to see the funny and ridiculous side of things.

Beverly’s religion is important to her and has helped her to be accepting and positive.

*He’s not necessarily going to help me with the cancer, whatever He’s got planned for me will happen. If it’s meant for me to go with cancer I’ll go with cancer, if it’s meant for me to go and walk out on the road and get hit by a car then that’s what will happen. I believe in God and that he will do what’s right for me even if I don’t know what that is.*

Beverly demonstrates her positive attitude in another way.

*I think it [pain] keeps you aware that there is something going on in your life that is life threatening so therefore make the most of what you’ve got now. Whereas if you didn’t have the pain you may take things for granted that under normal circumstances would be OK to take things for granted, but the way things are in my life I don’t think I should take for granted ... I don’t want to know how long I’ve got, but to make the most of the time I’ve got ... to appreciate life as it is now and enjoy what is in my life now and not put off enjoying till tomorrow. Making the most of what I’ve got today.*
The past for Beverly assisted her to make sense of her pain. It provided a way for understanding, which was borne of a time in her childhood and youth when she was disfigured with the treatment for eczema. *I had it all over my face and my arms and I had to wear a mask, with grey tar ointment on it and I used to get slung off at by kids and I had to get used to that.* She also refers to the asthma she had as a child, which she describes as, *that wasn’t an illness that was just an inconvenience.*

Her understanding is that she deals with her pain now in ways she learnt as a child. Her experience of illness and pain in the past has prepared her for the challenge she faces now.

*I said I wasn’t a patient person and when I hurt my back I had to fight to get any money as a result of my back accident and I think that kept me going for quite a while. I think that taught me patience like I was when I had eczema.*

**DISCUSSION**

The themes identified above have provided an insight into the ways that the six people in the study know their pain. The ways they understood the meanings the pain had for them and how they acted in response to those meanings was very much part of the an unconscious or primary way of understanding their relationship with the world and their pain. Heidegger, stressed that knowing exemplifies “the soul’s relationship to the world” (1962, p. 86). This is evident in the way the participants told their stories. Interwoven through the themes was the evidence of the way they were with
their pain and that way was the way they had always known. They had reacted or responded in ways they knew because it was part of the way they knew the world in which they lived.

The themes of balancing, living with threat, always there, and making sense of pain have identified ways of knowing that are common to the participants because of their existence in a world of shared language, culture and history. As mentioned in chapter three, Heidegger (1926/1962) contends that a person comes to know the world by the temporal and historical interdependence of culture, language and attitudes. The primary way of knowing is invisible and is made visible through experiences. The identified themes have made knowing pain for these people visible. Heidegger, (1926/1962) cautions that knowing does not arise from the way in which the world acts upon the subject nor does knowing create the relationship between the subject and the world, rather it expresses what already exists. Things come to be known because of the meaning they hold for people and ultimately lead to a choice to respond authentically or inauthentically as ways of understanding the meaning of Being, as discussed in chapter three. The following discussion will be focussed in this way. The themes themselves will be discussed against the Heideggarian framework outlined in chapter three.

The ways of knowing the possibilities of their pain determined how each person would choose between the authentic and inauthentic way of living as a result of the ways of knowing pain. The continuation of a broader range of possibilities handed down through history and culture, even though they may not be currently popular, is a factor in the drive towards authenticity (Schatzki, 1992). Interpreting the narratives in this way demands the recollection that Heidegger does not put a moral value on these terms, which
serve to illustrate the relationship between a person and the possibilities offered and chosen [authenticity] or not chosen [inauthenticity], within the world of common history and culture. It is also worth remembering at this point that Heidegger (1926/1962) argues that it is anxiety [pushing forward] of coming to terms with our finite being as we approach death that is the focal point in a person moving towards authenticity.

The stories of Ida and Veronica suggest that they fluctuate between authenticity and inauthenticity, which Heidegger (1926/1962) maintains, is the usual way to be. They have a strong background of knowing the world through their independence and self-reliance, with Ida having a strong faith that God will care for her. However, they move in and out of these understandings of the world. Ida has at times, some doubts about her own strength to manage the pain and also about God looking after her, mainly when she had severe pain, causing her some fear and uncertainties. She at times spoke of her impending death with passivity; passivity interrupted by bouts of severe pain. Through attempts at balancing her medications, responses and dependence, together with her strong belief in God, Ida was able to move at times towards authenticity. However, at other times, the constancy of the pain/cancer and the uncertainty that the threat of pain brought, caused her to move away from authenticity and respond according to a limited range of possibilities suggested by outside forces. Even her acceptance of her mortality was at times threatened by her relationship with her son.

Veronica also has times of fear, worry and uncertainty in the face of the threat of severe pain, but these times were underpinned by her need to be positive. The factor(s) that were more dominant at any given time depended on the amount of pain she experienced at the time. Her concern and
uncertainties about her daughter, her life until she dies and the severity of the pain influence the movement towards acceptance of her death. The struggle between balancing dependence and her need for independence; the constant reminder of the cancer through her experiences of pain; worry about the future; and the threat of the pain to her future life, have combined to overpower Veronica at times. She is not able to live her life, as she would normally choose, independent and self-reliant, as evidenced by her narrative.

Jack’s story also suggests that he has been independent and self-reliant as ways of everyday coping. However, his narrative, supported by his wife, suggested that he was no longer able to live in the same way since experiencing severe pain. Jack’s ways of knowing pain demonstrate that he was in an inauthentic way of coping, not moving to be himself as evidenced in his narrative. Jack was suddenly confronted by his cancer and the resulting pain, which he described as an assault. He was challenged by the threat of the pain, and responded by attempting to balance the conflicting factors that were created in his life. He attempted to meet the overwhelming nature of the pain in ways that he knew and understood, such as creating a pain chart and categorising his doctors so he would have more control. However, these attempts at restoring the way things were, were not sufficient in the face of the meaning that the pain held for Jack.

Some of the ways of knowing pain [rather than the pain itself] for Ida, Veronica and Jack, caused a schism in the way that they normally conducted their life.

Alternatively, Mr Schmidt, Maggie and Beverly are more often authentic in their way of everyday coping because they know their pain through ways
that have defined their way of living in the world, that they have chosen in the past as well as during the threat of pain. Mr Schmidt, while not conforming to the way many people would respond to their pain, has been consistent in the way he has lived his life and also is consistent with the Germanic culture of stoicism. He has always been self-reliant and seen that pain and illness had to be endured. His narrative indicated that this is how he understood his pain. He exhibited some uncertainty about the increasing loss of mobility, which to him was worse than the pain, but also reflected that this was the way it was and had to be endured. Mr Schmidt’s story is not consistent with good pain management practices as described in chapter two, however, it illustrates that meaning and knowing is not necessarily consistent with good theory.

Maggie illustrated, through her story, her way of living throughout much of her life and her ways of knowing pain were characteristic of this. She was confronted by many challenges in her life and came to know a response through her positive appreciation of the choices open to her. The conflicts that Maggie encountered had much to do with mentally overcoming the threat of her many physical problems. She was able to make sense of, and overcome the threats of her pain by a strong belief in her own abilities to manage the pain. Although at times she became frustrated, it was not frustration against an external force, it was frustration that she was not putting in enough effort. She always attempted to balance this against her belief in her strength and equanimity.

Beverly chose to understand the meaning her pain had for her by relying on the strategies she had developed over the years when confronted by other threats. She had some uncertainties about what might happen to her pain and how long she would continue to live and the constant reminder of the
relationship between her pain and the cancer confronted her. She did not accept the threat as it presented to her and she used her belief in God and herself to enjoy the life she had with her family.

Whereas, Maggie, Mr Schmidt, Beverly, and Ida to some degree, had different understandings although they faced similar physical threats, they identified similar ways of coping day to day. Veronica and Jack also exhibited similar ways of coping day to day, responding more to the pain as a dominant factor in their life.

KNOWING, MEANING AND PAIN THEORY
The analysis above supports the contention by Heidegger, (1926/1962) and Gelven (1978) that the interpretation of metaphorical masks and symptoms are a means of uncovering the meaning of Being. The patients who participated in this study showed their masks and symptoms related to their life and their pain. Through phenomenological interpretation, the way they knew their pain became apparent and the meaning it held for them was uncovered. Meaning did not develop with the pain but it had always been there, “Dasein always understands itself in terms of its existence - in terms of a possibility of itself” (Heidegger, 1962, p. 93).

Heidegger’s concepts of authenticity and inauthenticity have been identified in the study as pivotal to knowing pain, in keeping with the place they hold in Heidegger’s philosophy (1926/1962). Chapter three discussed the relationship between authenticity and anxiety. It was said that Heidegger identifies imperceptible anxiety (Angst) as the awareness of authenticity as it is a result of inappropriate disclosure of understanding. Anxiety is the driving force towards authentic being. Working towards authenticity is the
more usual state of being rather than always being authentic (Ree, 1998). Inauthenticity is usually borne of acceptance of the interpretations at a cognitive level. As discussed in the analysis, The research participants moved in and out of being authentic, some more than others did. The important point is that, as has been seen particularly with Mr Schmidt and Maggie, that although they remained in pain, it did not change their understanding or meaning of their world as they had always known it.

Heidegger makes clear that understanding is not derived from knowledge, but is a primary or universal structure of human existence or a basic mode of Dasein's Being. It is the disclosure of the meaning of an entity. It has been this disclosure that has allowed the knowing of pain to emerge as an entity of Being.

Current pain theory has been detailed in chapter two and it is necessary to attempt to link that theory with knowing pain as described above. If this is not addressed then the two remain distinct entities, which is not suggested by the evidence. The difficulty in equating the two phenomena, knowing and theory, is that one remains within the philosophical, qualitative worldview and the other is solidly within the techno-rational world of quantitative evidence. Nevertheless, there is some hope that the work being carried out in understanding the psychoneuroimmunological dimension of pain, and the complexities of the notion of suffering in relation to pain, will eventually be able to address the philosophical notion of Being and meaning in relation to the physical aspects of pain.
This study has not set out to attempt such a union between the physical, the philosophical and the existence of pain, and it is beyond parameters of the research design. However, it is important to recognise that if knowing, meaning and understanding from within philosophical precepts are important factors within the world of pain, then strategies and mechanisms must eventually be developed to understand their connection with the physical presence of pain. This study has been confined to identifying the importance and the place of one philosophical approach to understanding pain. Price’s (2000) discussion of the relationship between sensory unpleasantness, and secondary affective dimensions of pain, suggests that a union between the physical and the philosophical may be developing without naming it as such.

Certainly the combined works of Buystendijk (1962a, 1962b), Degennar (1979), Kestenbaum (1982), Schrag (1982), Taylor (1992, 1994) and Olafson (1995), among others, have identified that there are philosophical dimensions to pain. This study has also identified and applied a primary philosophical concept, knowing, to pain within the existence of the person. However, the challenge remains to explain how these concepts operate within a physical environment.

**Palliative Care and Pain**

The philosophy and practice of palliative care in relation to pain assessment and management as discussed in chapter two, endeavours to provide a better way of living for people who are dying, by controlling pain and symptoms and by addressing social, emotional, spiritual and emotional concerns. The stories outlined above illustrate that palliative care did not sufficiently meet all the needs of the participants who were dying. Although they may have
received some aspects of care and degree of pain control that might not have been possible elsewhere, most of the participants were still in much distress and suffering. The themes identified above also illustrate that another method of identifying the needs of people who are dying is important. One method relates to the application of phenomenological understanding and interpretation in meeting needs related to the being of the person with pain. The phenomenological approach used in this study identified that care was not always effective, however, it would also be possible for this approach to identify when care is effective, thus giving credence to other forms of evidence in measuring the effectiveness of palliative care.

ACHIEVING RIGOUR IN THE ANALYSIS

As part of achieving rigour in the study, described in chapter four, it is essential to articulate the rationale embedded in the analysis described above. Congruent with Denzin’s model of the research process (1989) discussed in chapter four, the analysis of this research was conducted within a framework of my understandings, and interpretations of the life meanings of the participants. This was facilitated through the research process adopted, and described in chapter four, with its rules and parameters primarily with the intention of protecting the participants. The other essential factor embedded within the research process was Heidegger’s philosophy, which governed the interpretation and subsequent analysis. The congruence between the philosophy and the analysis has been foremost in the application of the analysis to the research data. This has been demonstrated by the words used to describe the themes themselves. By the use of “ing” at the end of descriptive words fundamental to the themes, it suggests a movement ‘towards’, consistent with Heidegger’s description of authenticity as a movement towards realising possibilities. In addition, the

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development of the themes has taken into account Kaelin’s (1988) four criteria for knowing as ontology, informed by Heidegger, and identified in chapter four. To reiterate, they are:

- encountering entities as they are present and/or absent to the person, not as seeking them out would reveal them;
- being in continuous interaction with the world;
- having a temporal and/or historical understanding of being-in-the-world; and
- being alongside - at the present time.

The words and gestures of the participants that represented these four factors were taken into account for inclusion in the analysis, and are presented above.

**SUMMARY**

The instinctive ways that the six people participating in this study knew their pain was important in their everyday way of coping. Balancing conflict, living with threat, always there, and making sense of pain have been identified as common ways of knowing pain. These are important to the person experiencing the pain, but equally, understanding these ways of knowing pain and how they can be used in the management of pain, should be important to the nurse also. In that respect ways of knowing pain should be an essential part of pain assessment and will be discussed in chapter six.
CHAPTER 6

PAIN ASSESSMENT AND SELF
PAIN ASSESSMENT AND SELF

English, which can express the thoughts of Hamlet and the tragedy of Lear, has no words for the shiver and the headache. It has all grown one way. The merest schoolgirl, when she falls in love has Shakespeare or Keats to speak her mind for her, but let a sufferer try to describe a pain in his head to a doctor and the language at once runs dry.


INTRODUCTION

This chapter will identify the need for the addition of another kind of pain assessment, by identifying gaps in the understanding of the participants who lived with their cancer pain, by the nurses caring for them. The data from each participant is examined individually because that is how pain should be assessed, as an individual phenomenon. This approach is supported by a Heiddegarian philosophy that was explored and justified in chapter three. The participants’ pain identified from the data is further examined within the framework of the pain management model identified in chapter two. This model identified that pain language, its pervasive nature, and the individuality of the pain response, are important factors to be assessed because they contribute to understanding another person’s pain. The method of assessment is also a contributory factor and this thesis has established that phenomenological assessment is a significant addition to other forms of assessment for people with cancer pain. Phenomenological assessment allows the knowing of pain, to be uncovered. As has been demonstrated in chapter five, knowing pain influences the outcomes for people who are living with pain.
KNOWING PAIN AND ASSESSMENT

Pain assessment was discussed in chapter two and it was found that pain is a pervasive multidimensional phenomenon (Ahles, Blanchard and Ruckdeschel, 1983; McGuire 1987) and therefore, should be treated in a multilmodal fashion in order to capture the different dimensions within a treatment strategy. Recognition of the multidimensional nature of pain also gave rise to the individuality of pain and the expression, “pain is what the patient says it is”. Scarry (1985) identified that language was bound up in the invisibility and inexpressibility of pain giving rise to a dichotomy between private pain and public acceptance.

It was also demonstrated that assessment was the key to good management of pain, although assessment was found to be wanting in a number of ways, as was the management of cancer pain. Assessment was also found to be a responsive approach to pain to determine the individual collective factors underlying each person’s pain and an important role for the nurse.

The components identified in the discussion in chapter two that have a direct influence on the experience of cancer pain include; the variable individual nature of pain, pain language, pain assessment and the pervasiveness of pain. These dimensions were assembled into a model (Figure 1, chapter two) that illustrated the interrelationship of each component on pain assessment and which hold possibilities of better outcomes.

The model provided a useful way of managing pain, through better assessment, that encapsulates the most common aspects associated with a comprehensive approach to pain assessment. The multidimensional aspects also described in chapter two, fit within the model, although this model
provides a much broader approach to pain assessment. The multidimensional aspects of assessment attempt to uncover the experiences of pain, which many assessment tools attempt to discover. A perspective from which to understand pain, not only includes the experience of pain, but also pain within the existence of the person. This position is one that has been argued by Buytendijk (1962a, 1962b), Degennar (1979), Kestenbaum (1982), Schrag (1982) and Olafson (1995). Buytendijk reasons that, “the real meaning of pain is only manifest in the full context of the existence of man” (1962a, p. 152). It is from this perspective that this study was conducted. As an extension of the analysis of knowing pain and in order to answer the second research question, each participant’s ways of knowing pain were examined to identify the implications for assessment strategies. As pain assessment is an individual process, each participant was reviewed separately. This is in keeping with the views described in chapter three that an analysis of the individual is possible within a Heideggerian framework, as the individual is an “instance of that activity” [general way of being] (Dreyfus, 1987, p. 263). Findings from this study indicate that understanding the ways a person knows his or her own pain is a valuable adjunct to other forms of assessment. Each participant in the study will be discussed in relation to assessment of his or her pain.

Ida James

Ida’s story and the analysis of ways of knowing her pain uncover two main areas that are important in the assessment of her pain. Ida described as devastating the fact that she needed to take medications all the time for her pain. Her pain therefore was not well controlled, she continued to have bouts of pain as she only took medications when she felt she needed them. This ‘as required’ approach to pain medication is flawed and contrary to current pain management strategies. Despite attempts to convince her of
this, Ida continued to refuse pain medication on a regular basis. Ida was also concerned about her medication as a contributing factor to constipation, which reinforced her medication routine.

Many current assessment practices might only uncover the fact that Ida continued to have pain despite medication, thus increasing the dose unnecessarily. I have recorded in my diary that on speaking with members of staff, with Ida’s permission, that they did not know that she did not always take her medications. It might also reveal that Ida suffered from constipation but not that she did not eat much, *I eat like a bird really, people bring me things but what’s the use I can’t eat it.* By using an assessment based on uncovering the things that matter to Ida, it would be revealed that she did not like taking *all those tablets* and another form of the medication could have been discussed with Ida. For Ida, having opiate patches would have been a much better option and one that would have controlled her pain better. Her constipation could have been better addressed if her pain was better controlled, she may well have been able to eat more, and take her laxatives, if she felt better. A bowel program could have been worked out with Ida that suited her better and with which she would be more compliant.

Ida’s independence was also a factor that should have been considered in her total pain management. Because of her need for independence, Ida put herself at risk by not requesting assistance when she moved around. She had two falls that did not cause any physical harm and they did not deter her from exercising her independence at other times. *I’ve had a couple of small spills but I’m OK, it was when I had a pain that made me topple a bit.* Again, better pain management would assist Ida in her quest to be independent without putting her at such risk of falling. It could have been put to Ida that she might benefit from consultation with the physiotherapist.
or occupational therapist to determine if other strategies would suit her and that would assist her independence.

Ida felt she was losing her capabilities to care for herself and was therefore concerned that she would have to be sent to a nursing home if she were unable to stay at the hospice until she died. This issue had a great deal of meaning for Ida and could have been addressed by linking each of the other issues already mentioned, and which also had meaning for her. Providing better pain control would have assisted Ida to achieve a better level of independence and a better level of well being, allaying some of her concerns. Although, when she was informed that she would be able to stay at the hospice, she was very relieved, I just broke down and cried.

Providing better support for Ida around the issues discussed would have left her with more energy to concentrate on the spiritual dimensions of her life. As has been identified in chapter five, Ida’s spirituality had long been a part of her life, and it provided much strength and support in her life, and gave everything else meaning for her.

The themes and sub-themes identified in chapter five provide an insight into Ida’s ways of knowing her pain that can assist the nurse in the assessment of her pain. Ida’s story reveals that her independence is of paramount importance to her, and so medication that would impact on that would best be avoided. She knew that she should coordinate her treatment by attempting to balance the pain she had and the medication she needed, although this was not successful. Ida lived with the threat of pain because of the uncertainty it caused in her life and to her sense of independence. Her own mortality was inevitable, and which she recognised. However, it was the threat it caused to her relationship with her son that she found difficult.
As she said, we have always been able to talk about everything before, but he will not talk about this [her death]. She says she would rather die now to prevent further suffering for others. She attempted to make sense of what was happening to her through her religious beliefs which provided great comfort to her some of the time.

Understanding these factors would assist the nurse to develop a tailored plan of pain management that would take into account Ida’s needs that are so much of her being. It became obvious that Ida was not compliant with the pain management treatment that had been developed for her and that had not considered Ida’s ways of knowing her pain.

VERONICA HAYES
Veronica’s story raises a number of aspects in relation to assessment. The meanings that pain held for Veronica primarily related to her need for control and independence, and everything in her life focussed on those two things. Veronica understood that the reason she did not always have good pain relief was because of the continuing deterioration of her condition. However, given the multifactorial nature of pain, it could be assumed that a decrease in the impact of the pain would assist in better pain management. The issues that had meaning in her life continued whether she was at the hospice or at home and so consistent strategies across these sectors would have been important. Proper pain assessment should have identified the issues that had meaning for Veronica and which were impacted on by the pain.

Developing strategies with Veronica to better manage some of her concerns about the physical and emotional isolation caused by the pain would have provided some relief and assurances for her. Living with the threat that the
pain presents is two fold for Veronica. Providing physical aids and involving better community supports to assist Veronica to be as independent as she was able to be without always having to rely on her friends would have reduced one threat to her existence, *I hate to ask them* [her friends] *all the time*. Continuing those strategies whenever possible when she was an inpatient at the hospice would have reinforced their effectiveness. Veronica has identified that she is always looking for ways to increase her control over her life and removing some of the fear brought about by the pain would assist her with this process.

The second way that Veronica lives with the threat of pain is through the severity of the pain itself. Again, her control is threatened but this time because of the pain’s severity, *it just takes over*. Understanding this meaning would promote the need for a multimodal approach to pain management. Veronica was taking opiates and adjuvant medications combined with radiotherapy. However, given the personally undermining effect of the severe pain, Veronica may have benefited from meditation and breathing techniques to assist her to maintain control. Other techniques could also have been attempted to determine which one suited Veronica. The threat Veronica had to live with was in not knowing how she would be affected by a severe bout of pain and if she could initiate the help she would need, *I felt quite frightened, you are at home with no help and it was an awful experience and very severe*. Developing strategies with Veronica to ensure she would be able to get help when she needed it would have provided some measure of security for her. Strategies that incorporated electronic and telecommunication devices as well as personal contact would have been an important adjunct to her management.
The themes and subthemes identified for Veronica, in chapter five support the view that her pain is a complex phenomenon in her life. Her independence, the pain as a threat to that independence through the uncertainty and control it had over her, its constant presence and subsequent worry and her strength in attempting to remain positive provide valuable insight into understanding Veronica as a person-in-pain. Without assessing the meaning of the pain for Veronica these issues would not necessarily have been uncovered and addressed in a planned way.

**Mr Schmidt**

Mr Schmidt's story highlighted a role for the nurse in assessment in order to address the issues uncovered by this study. Mr Schmidt used his energy in balancing the pain with his control because that was how he had known pain that he says has always been there and with which he has always lived. His total belief of how his God impacts on his life supports his strategy of control.

The staff assumed, as recorded in my diary, that if Mr Schmidt did not complain of pain, then he did not have any. As his story indicates, he did not always tell staff when he had pain, *what could you do anyway?* This perspective reinforces his long held belief that, *I just put up with it.* At times he was asked about his pain but this was not sufficient to determine the amount of pain that he experienced or its severity. On reference to my diary I believe that he underrated his pain in the belief that nothing more could be done. My entry indicates that,

*Mr Schmidt was reluctant to discuss any pain on the nurse's invitation to do so, although his wife later told the nurse that Mr Schmidt told her that he had a*
lot of pain. His wife also indicated that when he rubbed his leg it was an indication that he was in a lot of pain.

Mr Schmidt’s need for certainty and maintaining control over his life to the exclusion of other things, even good pain management, should be identified in an assessment of his pain. Mr Schmidt believed that the staff already knew about his pain, there is no need to tell about the pain, they are all well aware of it, the people around me. He also had a strong belief that he should manage his pain himself, you accept the situation as it is, that’s all, it is once you accept it, there you are and, that his strong sense of personal integrity is threatened by ‘complaining’ about his pain. These issues have meaning for Mr Schmidt and they interfered with adequate pain management. Because of his disease the pain was likely to increase over time and so it was even more essential to attempt to gain better pain relief.

If the nurse had the understandings as outlined above then better communication would have been an option for improving pain outcomes with Mr Schmidt. Better communication would also identify more meaningful ways of addressing Mr Schmidt’s pain that incorporated his need for control and the way he viewed his world. His concerns would have been able to be canvassed with him and assurances provided that pain was not considered a sign of a malingerer, and that the staff did not always know when he had pain or how often. Knowing this would allow his medication to be adjusted to better meet his needs. These strategies would not be based on the staff overriding Mr Schmidt’s identity because they knew better, but the strategies would be underpinned by Mr Schmidt’s way of being, whose ways of knowing his pain would contribute to better pain management.
MAGGIE PETERS

Maggie displayed many positive aspects as ways of knowing her pain. She used mental strength, meditation, and physical exercise to overcome living with the threat of the pain and cancer to her existence. She worked hard over the years at balancing the long-term medications, the frustrations and the perceived stigma, with her strength and positive approach. Despite episodes of severe pain she remained positive and grateful for any assistance.

However, an assessment of the ways Maggie knew her pain would uncover two issues that she alluded to a number of times, although she did not provide any detail as she did with all the other factors that she talked about. The first was her marriage that she only mentioned in any detail in her diary, which was returned to me, only after she died. In the diary she wrote:

Being a victim of domestic violence, it is difficult to separate the emotions of what is medically called anxiety neurosis and the real, but medically unrecognised condition of tension in muscles etc. The constant tension caused by fear for oneself and the children. Fear caused by physical assault by one partner - usually the male - and verbal assault. So muscles tense, sleeplessness may set in, headaches occur and unless steps are taken to improve the situation the medical condition of pain and suffering sets into progress on the victim’s body and mind.
Maggie's condition deteriorated and she died soon after this last entry.

She always had kind things to say about her family although she would often hint about problems with her daughters not understanding. She referred to this in her interviews:

The anger and resentment were more aimed at all those people who wouldn't believe my statements of severe pain whether they be medical or non medical. And what I mean are family, in a domestic situation, but I've always tried to overcome those emotions, they are a hindrance to dealing with the pain and to getting well. I still use my own resources because so many doors have been closed - the professional and family doors were closed. I have had a lot of illness and a lot of pain to put up with without any domestic or family help. The professional doors have been closed because of the shrugging and the disinterest, the family doors have been closed because of the professional shrugging and disinterest.

I believe if these issues were explored more with Maggie, it would have uncovered another way of knowing her pain. Maggie was taking large amounts of opiates and adjuvant medications, was practicing meditation, and was receiving massage, hot packs and physiotherapy all in a bid to reduce her pain. She had regular medical assessments to determine if there were other medical causes for her pain. She continued to have severe pain at intervals. She made the link between her abuse and the pain she suffered.
Her understanding that her daughters did not believe or support her in her pain compounded the abuse she suffered within her marriage. Unfortunately, these issues were not addressed before Maggie died and I believe they were important in the whole scheme of Maggie’s pain because she kept alluding to them, vaguely, during my interviews. Maggie’s story is an example of staff applying pain assessment strategies that did not uncover the real meaning of the pain in Maggie’s life. A planned approach to uncovering her knowing would have provided a more profound assessment and identified Maggie’s way of knowing her pain long before she died. Maggie was obviously reluctant to discuss the issues that had a meaning for her in a way that was not revealed, and certainly it was her right not to disclose it. However, a sensitive and compassionate approach may have assisted Maggie to understand that other people could help her with her pain. Given her past history with health professionals and her almost absolute belief that she was the only one who could help herself, it would have been a difficult task. As it was, the staff had no understanding of the issues that drove Maggie to endure what she did. The themes and sub-themes identified in chapter five provide an indication of the struggle that Maggie knew in relation to her pain. Balancing many conflicts through balancing pain and response; balancing pain and perception; being strong/being frustrated; living with threat and trying to overcoming threat; believing; and being positive, give a sense of the level of activity she was engaged in to mange her pain in the ways she knew.

**Jack Taylor**

Jack conveys a story of someone whose pain has taken over his life. He was constantly balancing the conflicts in his life, as he sees them. For a short time he attempted to make some sense of it by going to his shed and doing some carpentry. The ways he knew his pain offer some insight into the need
for more adequate and regular assessment of his pain. His pain had not long been so severe and his medication was in need of further adjustment. He also required investigations to determine the cause of the increasing pain, as this kind of assessment had not yet been undertaken.

Because of the way he presented with his pain, there were opportunities for a more comprehensive approach to his pain assessment and management. The threat of the pain was so overwhelming for Jack that it indicated that some psychological and personal support was required, not just to deal with the pain when it was severe, but to assist him to regain some hope and control in his life. Unless this way of knowing pain was assessed, this aspect might not become obvious unless Jack became noticeably clinically depressed, which he already talks about. The literature on suffering, discussed in chapter two would suggest that Jack was suffering as a result of his pain. He indicated this when he says his pain is an assault.

At times Jack seemed to be in control, he’s a strong person anyway - he’s always been a strong person [Gloria] and Jack responded, I don’t know myself that well, people tell me that, but I don’t know, I don’t think I’m any stronger than anyone else. You got to do what you’ve got to do don’t you. This aspect could have been misinterpreted if pain assessment was only based on a tick sheet, because underlying that were the changes and the threat brought about by the pain and cancer.

I’m so tired and dopey you know, but I’m strong enough to cope with it at the moment. Just sick and tired of the bloody thing. Backwards and forwards, backwards and forwards. The wife’s moved out of that bedroom into another bedroom because it kept
disturbing her. At one stage I was laying on the lounge, I’ve tried different cushions but I can’t have anything - the pressure. That’s why I’ve got this one with the circle, it’s the only way I can sit. I can’t sit on a chair normally or on a normal cushion. You get depressed by it, you go to read and you nod off. I used to be a big reader and I just can’t read now. It takes me ages to read the paper and my book. I’ve been trying to read it for a few months now and I’ve only got through three to four pages and it’s not a bad yarn either. I keep nodding off and I have to keep going back to where I started. I got sick and tired of that.

Gloria added:

He can’t go anywhere. He was going to go away for a couple of years but he can’t now. (Laughs) It’s getting less and less time out there (in the garage). His hours out there isn’t very long anyway, at one stage you were doing three hours, but you’re not now.

Jack responded, lucky to get out there now. Things have changed - I’m having the chemo - different people come to see me I don’t have a chance to get down there now. [Earlier he had said that he did not receive visitors anymore]. These aspects of Jack’s life with pain are important to pick up on because it provides insight about the depth of the impact of the pain.
on his life. He had not confided in his doctor who, at the time, was not aware of the extent of his pain and it has therefore remained undertreated.

A number of strategies could have been implemented in conjunction with better medication. Jack often alluded to the fact that he did not know what was happening, and that would have contributed to his pain. It would have been important for the nurse to act as a case manager to initiate a number of activities to identify the cause of the pain and its treatment. An urgent assessment by Jack’s specialist to determine if there was increasing pathology causing such an increase in pain would have been important. Discussion between the specialist, GP, the nurse and Jack and Gloria would have assisted in meeting their need for information and understanding about what was happening and to coordinate his care. I found it incredible that even though Jack saw the nurse when he received his chemotherapy, and occasionally the doctor, he did not come away with any of his fears allayed or questions answered. This in part was due to the fact that Jack did not ask questions and relied on the staff to initiate communication. He expected them to find out, if they need to know they will ask me. It was, therefore, essential that the nurse realised how Jack understood the relationship with medical professionals and then sought to balance that. By knowing how Jack understood his pain, then the nurse would have been able to implement better strategies to ensure that he had all the information he needed and that the staff initiated the communication and provided the information and support. By maintaining honest and open communication with Jack and Gloria, the threat of the pain may have been significantly reduced. It would also recognise the efforts that Jack had made to deal with his pain and reinforce his personal strength. This approach with Jack would take some time and effort but should be an essential part of his care.
Jack's pain chart demonstrates that his pain is increasing, but it does not indicate all the factors that are impacted by the pain or that impact on the pain. Understanding that Jack had spent his life building things and has tried to continue to do so despite his pain, is important when working with him to manage his pain.

Unfortunately, as has been identified with Mr Schmidt, if people do not tell of their pain, or if they do not ask questions then it is often assumed that they do not have pain or they have the information that they need to have. It has been demonstrated with Mr Schmidt and Jack that the issue of communication and its place in the life of each of these people has been integral to their pain, and overlooked. Using a planned approach to uncovering what and how people know their pain would have assisted in identifying and resolving this problem.

**BEVERLY ADAM**

Beverly was still quite mobile and independent. It would have been easy to dismiss Beverly's pain with a quick assessment of the level of pain to determine if she had adequate analgesia. However, assessing Beverly in terms of the ways she knows pain allowed an insight into ways of supporting her in her endeavours to manage her pain. In addition it would have provided a baseline for assistance with future management as the pain increased because of deterioration in her condition.

Beverly demonstrated her strengths through her acceptance of changes in her life and her learning and adapting, over time, to live her life as it had meaning for her, *I know what I have and how to manage it. I have learnt that and how to be patient and now I'm learning other techniques to help me.* It is equally important for the nurse to acknowledge and build on
strengths, as it is to identify and work with limitations. An example of this is the nurse who was working with Beverly and who, in recognising Beverley’s qualities supported and assisted to strengthen them enabling Beverly to have the confidence to manage her pain and cancer in a positive way. Beverly was taught breathing and meditation techniques, which she found helped her to manage her pain, especially at times when it was quite severe. It was also a support for her knowing that she had some strategies to fall back on when she had those moments of uncertainty about whether a bout of pain means a progression of the cancer.

Understanding the way Beverly knows pain and the meaning it had for her, assisted her nurse to tailor a plan that suited Beverly and that was based on her positive approach to her pain and illness and was designed to address those times of uncertainty.

I have some strategies to deal with the pain, but if I’m in a very negative attitude then there’s no way the strategies will help me. I’ve just got to work it through and the pain has just got to work itself through. Whereas if I’m not thinking about the cancer or if I’m in a positive frame of mind then I can immediately start working lets get on with this, lets think positive and think about the good side of things and then I can get on top of it. It’s how I am when the pain starts not how you can get yourself into after it starts. That’s why I am working on being positive most of the time.
Beverly does not have the same kinds of conflicts that other participants have, although she does have a number of concerns that she attempts to work through. She has been fortunate in that she has found a nurse who is able to ‘be with her’ as she travels her journey with pain and cancer. Beverly’s situation also identifies the need for understanding ways of knowing pain early in the continuum of pain and cancer, so that the person is able to build up strategies that will also assist in the event that the pain deteriorates over time.

PAIN ASSESSMENT
Pain assessment using the ways people know pain and the meaning that specific aspects have for a particular person are essential to a comprehensive assessment of cancer pain. It is this assessment that will influence more adequate management of the pain as has been demonstrated in this study. The multifactorial nature of pain is personalised and therefore demands a tailored assessment and management plan for people with cancer pain. Reviewing the factors that contribute to pain assessment and that were discussed in chapter two, and applying the findings from this study to those factors will further support this contention and lead to a new model of pain assessment. To recall, the assessment model is built on a number of factors that include pain language, its pervasive nature, and the individuality of the pain response. These factors are interrelated and although commonalties exist within human existence, identified in chapter five, assessment is based on individual meaning and response, as an extension of the common understandings that people have. The common areas identified for the six people who participated in this study provided the groundwork on which to extend the analysis to the assessment process. For example, one of the
themes identified was balancing conflict, and so it was important to understand that five of the six people with cancer pain who participated in the study, balanced a number of aspects of their life that were impacted by, or impacted on, their pain. Balancing conflict was a factor in managing or responding to pain, and as demonstrated in chapter five, each person balanced a different combination of factors because of the different meanings that pain had in their life.

The study has promoted another way of assessing pain, by listening to the person who exists with the pain, understanding it from the way he or she lives and knows their life. This then makes possible an assessment based on individual existence and the entities that structure being-in-the-world, which are as important as the dimensions of pain.

Grossman acknowledges that assessment of cancer pain is frequently neglected and he suggests that a comprehensive assessment is the prerequisite for appropriate intervention and subsequent pain relief. He then recommends that assessment must be quantifiable and yet allow for the “entirely subjective nature of pain” (1994, p.105). This study has demonstrated the complexity of the collective features that have a dynamic relationship with the person and their world and thus supports a multidimensional form of assessment and extends it by incorporating a phenomenological approach of knowing.

Harrison (1991) states that bias and inaccuracy are common features of pain assessment. A synthesis of her supporting arguments suggests that a lack of understanding of the person-in-pain is a primary cause and is substituted with assumptions based on an inaccurate understanding of the person-in-pain and pain mechanisms and treatment.
It is more time consuming to listen with an open mind than to tick boxes on a chart, but a way of assessing that promotes an intimate understanding, not just of the pain but also the person-in-pain. It allows another level of personal communication of pain previously blocked, because the pain “possesses us: we are the pain” (Somerville, 1994, p.46) thus destroying what language may have been available. This was exemplified by Maggie Peters’ story, which created such a profound sense of understanding her pain, in contrast to the chronology of medical events told by the staff caring for her. The distinction was palpable. Listening to and understanding Herbert Schmidt, Jack Taylor and Veronica Hayes, it became obvious where there was need for intervention to assist them to move forward with better pain management. Beverly Adam was fortunate enough to have access to a nurse who did engage in listening to the way Beverly lived her life with pain and was able to build on those qualities that already belonged to Beverly. Listening to the language of the person-in-pain also eliminates the problem of the nurse asking the wrong question. Many nurses ask the question “how is your pain?” and if the patient does not have any at that precise moment, he or she will answer to the effect that he or she does not have any. But this does not bring to light that the patient may have been awake all night with pain, or has frequent episodes of pain, as was the case with Jack, when his GP asked how his pain was. This also occurred with Mr Schmidt who did have pain, but because he accepted that he should have pain and that the nurses would know this, he would answer “OK”. Asking direct questions of patients about their pain can sometimes obscure the real situation because of the interpretation of the question by the patient and the meaning that the pain has for the patient. Pain questionnaires also have the potential for misinterpretation and can also contribute to this situation, also because the language used may not be how the pain-in-pain knows his or her own pain.

Chapter 6 - Pain Assessment and Self
Grossman acknowledges that assessment of cancer pain is frequently neglected and he suggests a comprehensive assessment is the pre-requisite for appropriate intervention and subsequent pain relief. He then recommends that assessment must be quantifiable and yet allow for the “entirely subjective nature of pain” (1994, p.105). This study has demonstrated the complexity of collective features that have a dynamic relationship with the person and their existence and thus it promotes a comprehensive form of assessment.

McCaffrey and Beebe (1989) have promoted the dictum ‘pain is what the patient says it is’, but how do we know what that is. The findings from this study illustrate the different levels and dimensions of knowing pain. If by only using standardised tools that use tick boxes and analogue scales to assess pain, then how do we as nurses understand truly what the patient is saying, or indeed is unable to say, about what their pain is to them? Mr Schmidt, Maggie Peters and Jack Taylor in particular did not have the language to convey what they understood about their pain. While they had an understanding about their pain that drove them to ‘manage’ or ‘accept’ their pain in ways they knew, they were unable to share that understanding with the medical and nursing staff. Because this study has identified another way of assessing pain, nurses will be able to use it to trigger stories that tell of this way of knowing pain, where there are no single words or sentences that conform to a standard benchmark about pain quality or incidence. The use of standardised tools only, serves to diminish the language of pain, rather than promoting it. Harrison (1991) states that bias and inaccuracy are common features of pain assessment. A synthesis of her supporting arguments suggests that a lack of understanding of the person-in-pain is a primary cause. Findings from this study indicate that
understanding ways a person knows their own pain is a valuable form of assessment.

**PAIN LANGUAGE**

This study has given voice to the person’s way of being-in-pain, not by adding to the pain language but through the language of the person who knows his or her own pain. It has allowed the pervasive nature of cancer pain to be expressed in the way individuals know and live with their pain. The participants of this study did not talk about the type and severity of their pain. They used language they were comfortable with to talk about what the pain meant to them.

As discussed in chapter two, Scarry (1985) identified the inexpressibility of pain and its subsequent destruction of the sufferer’s language, but contends ways exist that remake this personal world. Illuminating the unknown, allows the pain to be shared in some small way, thus alleviating part of the burden, with the possibility of enhancing physiological functioning (Ruff, 1997; Felten 1993) and is the first step to compassion, the ‘being-with’ that serves to promote healing (Cassell, 1991) and remaking the world. Better understanding means better and more appropriate intervention (Bruera & Watanabe, 1994). Jack stands out as the person who would benefit from this approach. However, reviewing each person’s story from chapter five, each of the participants would benefit from a compassionate being-with way of listening. Each person was troubled in his or her own way that contributed to the pain.

As identified from the stories of each person, it is only through hearing many dimensions of their pain that the language they use has meaning and is able to present an understanding of their pain. This is not possible using
brief descriptors that may not have any pertinent meaning for a person especially in relation to their fuller existence. This study has identified a number of factors within the themes and sub-themes that together present a story or language of pain for each person. It has contributed to understanding the complexity that pain has in a person’s life and that cannot be re-told using pre-determined categories or descriptors.

**Variable Individual Nature of Pain**

The study illustrated the differences between individuals, referred to earlier as the ‘subjective nature of pain’. Although, as was demonstrated in chapter five, there exist common understandings that underpin ways of knowing pain, it has been demonstrated in chapter three that individual ways of coping can be derived from these common understandings. This is seen in the way threat, or suffering, is part of people’s pain. For Ida, the threat is manageable for the most part, because of her belief in God. For Veronica and Jack the threat to them is much stronger, and they have not found a way of managing it. Cassell speaks of the individual differences in suffering, which he contextualises within time and relationships, “a sense of time is necessary for suffering; more than a future there must be an enduring past. I must have some sense of how I am constituted and what I can do to fear the loss of a piece of myself - and for that I must have a past” (1991, p. 211). It is the common understandings of the participants identified in chapter five, that give rise to subjective interpretations of those understandings (Heidegger, 1926/1962). Living-with-pain, in a world with other people, pain is a hurt that we feel and is a private sensation that is not always able to be communicated directly, “all efforts to define the subjective sensation, whether by logical analysis or objective attempts at operational definitions, seem always to come full circle and end as imperfect communications of a subjective experience” (Sternbach, 1968; p.1). By traveling the circle as
Heidegger (1926/1962) suggested, and coming into it in the right way, the problems of language and hence assessment can be overcome.

The variable individual nature of pain would also include the individual response to multimodal and multidimensional aspects of pain that were discussed in chapter two. The multimodal concept of pain, distinguishes the number of different contributing factors to pain that may complicate assessment of pain. These considerations are of paramount importance in any assessment of pain. Each of the participants in this study had more than one physical source of pain, and also experienced other non-physical contributing factors to their pain. Each patient at the hospice completed or had completed for them, a pain assessment chart that attempted to identify these factors. These charts did not communicate the issues that this study has identified and pain was not well assessed by the staff who cared for the participants in this study and if individual members of staff undertook appropriate assessment it was not communicated well. This is evidenced by the fact that the participants either continued to have pain at an unacceptable level or that they also did not understand the need to discuss their pain with the staff. Pain assessment tools have been developed to include many aspects of pain, although it is not clear whether the same understanding of a person’s pain could have been identified through the solitary use of such tools. The tools measure the experience of pain, not pain within a person’s existence. This is seen within the structure of the tools and how they rely on the efforts of the patient to complete.

The Edmonton Symptom Assessment Tool (Bruera et al., 1989; Bruera et al., 1991) and the McGill Pain Questionnaire (Melzack, 1975) are tools that endeavour to assess the multidimensional factors that impact on pain. Unfortunately as with many other tools they are not easy to use in the
clinical setting (McGuire, 1984b). In addition to the need for the patient with pain to focus on a long survey/questionnaire form, the patient also has to try to fit his or her pain into a pre-formatted language and description, that he or she may not recognise in terms of his or her own pain, culture or language. The advantages of using a method of listening to the person with pain as happened with the six participants, are that the nurse would be the person doing the ‘focusing’, on how the person knows his or her own pain, and that the nurse is doing the ‘difficult’ work of assessment and not the patient. The patients’ task is made easier because all they have to do is to convey what is known from their own life in their own language. It is up to the nurse to interpret and validate it with the patient not the other way around, as is the often case with assessment tools.

**Pervasive Nature of Pain**

The pervasiveness of pain has already been mentioned in relation to language and subjectivity, but its importance necessitates that it is discussed separately. The work being done in relation to the psychoneuroimmunological implications for pain, discussed in chapter two, support the pervasive dimension of pain. Pain felt in one area of the body could have widespread implications for the whole person. This is so if the pain is related to cancer and/or if it persists. Each participant exhibited pain that was pervasive in that often more than one type of pain was experienced and each had to live with the pain and the idea and which impacted on many aspects of living. In addition, the concept of “total suffering” has enabled expression between a number of different factors and pain. Jack Taylor stands out as an example of this kind of suffering, which once identified could be better managed with assistance tailored to his needs. These other factors include other physical symptoms, psychological problems, social parameters and difficulties, cultural factors and spiritual concerns.
(Woodruff, 1996; McGuire, 1992). Woodruff (1990) makes the point that these interdependent relationships indicate that attempts to relieve pain will not necessarily alleviate all the suffering, which may be manifest by increased pain levels. The multidimensional approach to pain, also discussed in chapter two, also supports a pervasive dimension of pain although, it does not always unravel the complete story because it focuses on experiences only. This view is supported by the fact that many multidimensional assessment tools rely on a tick box approach or lengthy questionnaires with pre-ordained language, thereby immediately diminishing the language of pain and the existence of the person with pain.

As discussed in chapter two, often assessment is restricted to one or two aspects of the nature of pain, usually the physical and behavioural aspects. However, using a phenomenological approach will assist the nurse to define those aspects that relate to the existence of the person. The multidimensional assessment discussed in chapter two is an approach that attempts to capture the pervasiveness of pain, although it is not often used in the clinical setting. The patients in this study talk about the many aspects of their life that are implicated in their pain by the very fact that the dimensions of their life have meaning for the person. Relating these aspects to the whole context of the person with pain, their language and subjectivity, is one way of apprehending the “shadowy fraction” of the “aversiveness” of pain (Scarry, 1985, p.4).

A NEW MODEL
Each of the dimensions of pain that has been discussed is important to the experience of pain and is supported by this study. However, better understanding of individually experienced pain can be achieved by
including the ways of knowing pain that are based on meaning and existence rather than experience only. Experience and existence are not easily separated, the former being part of the latter. Heidegger (1926/1962) refers to existence as the primary understandings that people have that lead them to behave, talk, act in a certain way; "That kind of Being towards which Dasein can comport itself in one way or another, and always does comport itself somehow, we call 'existence'" (1962, p. 32). He also maintains that "the 'essence' of Dasein lies in its existence" (1962, p. 67). In contrast, Heidegger, refers to experiences as those actions that impact on a person, "Dasein becomes something that it can itself 'come across' only when it looks away from 'Experiences' and the 'centre of its actions'..." (1962, p. 155). Experiences can be interpreted as the more concrete, specific or local activities, or the "existentiell". Heidegger has identified that experiences do not constitute all the entities that are understood as a means of existing, in fact they are limited in this respect by the very role that Heidegger assigns them.

As existence is not a tangible entity that can be isolated and easily dissected, it needs to be understood from the common background that provides the knowing way of life. It is only by moving through the meanings that people have developed and that need to be made manifest, that these common understandings of existence and also the individual ways of applying those common understandings can be interpreted. This study has identified the common understandings in chapter five and in this chapter, the individual applications of those understandings in the assessment of pain. As a result, it has become clear that in order to understand another person's pain, another dimension should be added to the model identified in chapter two. The dimension is one of knowing pain, a knowing that has evolved with the common understandings of living in a common world and that identifies its
personal application. A new model depicted in figure 4, and based on existence and experiences presents a more complete pain assessment exemplar. The model is based on figure 1, chapter two, with the addition of a circular path around the assessment process but which touches the other dimensions that contribute to assessment of cancer pain. The Pain Assessment segment includes all the other mechanisms of traditional pain assessment, which are informed in part by an understanding of pain that is gained through a phenomenological process of knowing another’s pain.

Figure 4: A New Model of Cancer Pain Assessment
VIABILITY

The viability of such a model in the clinical setting is important. Listening to the patient is the basis of the process presented above and to this study. One of the issues this approach has for the clinical area, is one of time. For such a process to be acceptable to nurses it needs to be time efficient. Listening to the person-in-pain does not necessarily have to be very time consuming. The clinical setting does not need to be equivalent to the research process. Listening to the patient in a clinical setting does not need require an interview over a number of hours. It can be a process of skilled listening where the nurse is attuned to what the patient is saying at the time, reflecting on this, validating it with the patient and applying it to the pain management strategy. The underlying assumption is that the nurse is uncovering the meaning the pain has for the patient, with the criteria presented in the model as a framework. This may occur over a number of interactions between the patient and the nurse or nurses, who would communicate their interpretation to other staff so that a plan of care could be developed, and to ensure continuity of care. Importantly time need not be specifically designated for listening as it can occur during other nurse-patient interactions and interventions (Taylor, 1992).

ACHIEVING RIGOUR

Application of the process described in chapter four to achieve rigour, has continued in this chapter that has described the importance of knowing pain as part of the assessment process. In doing so it has achieved credibility through use of subjective reflection using a journal, and reference to the whole story from each participant. This is evidenced by my narrative that supports the claims made within the text. Applicability is evident by the use of appropriate and descriptive quotes from the participants that demonstrate
a need for more adequate assessment. The participant's own story also reflects the relationship between ontological knowing and assessment, bringing together the threads of the work covered in chapters two, three, four and five. In doing so this chapter has adhered to the philosophical framework, which underpins it. This is evident throughout by the integration of the Heideggerian concepts of knowing, understanding, meaning, and self, in addition to the ontological findings described in chapter five. The work in this chapter is also underpinned by much of the pain literature discussed in chapter two, and links to the model subsequently developed in that chapter. In achieving consistency, concepts of assessment and self link the major concepts identified in this thesis.

SUMMARY
Assessment of pain remains an individual process but one, which this study has identified, is based on the commonalities of people living in a common world. Although it cannot be derived from this study that a more tailored assessment and plan of care for these six people, would provide better pain management, the literature and research on the complex mechanisms of pain would suggest that this would be so. It can be said though, that assessment of the ways people know their pain would contribute to better understanding of the person-in-pain by the nurse, and is an important factor in the management of cancer pain.

A model of pain assessment has been identified that incorporates the multidimensional approach to pain in addition to other factors that are important in the total assessment of cancer pain. As a result of this study, a new model is presented that incorporates the relationship between experiences of pain, and pain within human existence. The implications of
the study for nursing and recommendations for further research and clinical application will be discussed in the proceeding chapter.
CHAPTER 7

THE END OF THE JOURNEY
THE END OF THE JOURNEY

Albeit enriched by the journey, we have only returned to where we were at the beginning of our inquiry. Kaelin 1988, p. 92

INTRODUCTION

This chapter brings to an end the journey travelled in the quest to extend understanding about people with cancer pain in a palliative care setting, and their interactions with nurses as these interactions relate to pain assessment. As Kaelin (1988) indicates, the study has returned to the beginning of the circle of understanding, although with more knowledge and more questions.

The process underpinning this study is important in itself and is concluded with the discussion in this chapter, which will:

- Identify the value of the study;
- Discuss the implications of the findings for nursing in terms of the clinical applications from both the process and the findings;
- Suggest areas for further nursing research and education; and
- Identify the limitations of the study; and
- Discuss the ongoing process for achieving rigour

It has already been discussed in chapters one and four that the presentation of the process of inquiry for this study has followed a circular path. It began by entering the circle at the level of the everyday concerns and considerations of cancer pain already within the literature, and in this researcher's experience, and thereby identified the problem. Each chapter
became part of the circle by disclosing more structures and entities to support the explication of the ways people with cancer know their pain, uncovered in chapter five. The first four chapters identified the beginning of the circle that revealed the entity under consideration. Chapter six connected the findings from chapter five, using further analysis, to promote a practical application of ontology to pain assessment.

VALUE OF THE STUDY
The value of this study lies in the acknowledgement of another way of knowing that is inherent in the phenomenon of pain. It has implications for understanding what knowledge is, how it is valued, and importantly how different kinds of knowledge can be linked. In particular, it raises issues about the preparation of nurses and the educational support they need to understand the value of the interactions they have with patients in the clinical setting. More specifically, the study also identifies an area for further research to demonstrate the implications of education and the implication of a phenomenological way of nursing in a palliative care setting.

This study has explored the ways of knowing cancer pain in a palliative care setting. An examination of the literature supported a concept of knowing within an ontological perspective, and in particular within Heideggarian philosophy, found in Being and Time (1926/1962). In addition, it has identified through the literature, that pain assessment is not well done by nurses resulting in poor management of pain. The study findings indicate that pain was not well controlled for the people who participated in this study and the ways they knew their pain were integral to the person-in-pain. It is suggested that because of the essential role of knowing pain that it is
also important in the assessment of the pain, and could well influence pain management strategies and better outcomes for the person-in-pain. As a result of this examination of the literature and the subsequent data analysis in chapter six, a legitimate place was identified for the individual within the universality of Heidegger’s concept of Being, resurrecting with new emphasis, the debate begun by Crotty (1996), and explored in chapter three.

The findings of this study in answering the two research questions outlined in chapter one, have identified through the themes and sub-themes in chapter five, the ways people with cancer pain know their pain, with implications for how they respond to pain and treatment, according to these ways of knowing. As mentioned above, this study supported the view, from the perspective of the patients participating in the study, that the pain in many instances was not well controlled in a palliative care setting, raising concerns about the role of the nurse. Chapter six identified the importance of pain assessment by the nurse. The data suggested that the nurses did not always have the understanding of the ways their patients knew their pain, although this connection would need to be validated with further research. In responding to this finding and in conjunction with the dimensions of pain assessment discussed in chapter two, a new model was offered to extend the pain assessment process. The results discussed in chapter six also support the value of the individual within a universal ontological philosophy. This issue has more relevance for nursing, than Heidegger’s Nazism has, as suggested by Holmes (1995), because of the integral place of the individual in nursing philosophy and practice.

**IMPLICATIONS FOR NURSING**

Chapters two and three argued that nurses have a role in pain assessment and that phenomenological understanding has a role in nursing. The
differences highlighted between these two roles are that the former has a clinical application and the latter more of an academic application. One value of this study is that it connects these two areas by advancing an alternative method of cancer pain assessment. As discussed in chapter two, as early as 1979, Jacox (1979) was urging nurses to conduct a more informed and compassionate assessment of pain than was the normal process in the 1970s. The findings from this study has identified that nursing has not yet fully embraced this plea. The connection was also made between assessment and better pain management and formed the basis of the analysis in chapter six (Harrison, 1991; McGuire, 1987; McCaffery & Beebe, 1989).

Parse (1981) and Benner (1984) in America and Parker (1991) and Lumby (1991) in Australia, have been among the first nurses who have attempted to influence the application of a phenomenological approach to clinical practice, although Parse’s model was not based purely on phenomenology. Many nursing research studies have used a phenomenological approach to understand nursing practice or issues that concern nursing practice, but have not always taken it further so that it has a place in everyday practice.

The application of the findings in chapter five about the ways that people know their pain as it relates to being-in-the-world, are important for nursing in two ways. First, the ways of knowing pain identified by the themes in chapter six, indicate a new approach to understanding pain. They suggest that other factors than those discussed in chapter two, impact on the way a person will respond to pain interventions. From the discussion of the literature in chapter two, it can be assumed that effective pain management depends on the factors that influence a person’s interpretation of his or her pain.
Secondly, the ontological underpinnings of the factors or ways of knowing pain are equally important. They allow the nurse to legitimately move outside prescribed measurement and assessment tools. It was stated in chapter two and is re-stated here, that the ontological assessment approach does not replace conventional assessment methods but rather is an addition to them. The congruence between the individual nature of assessment, nursing and ontology that has developed from this study is an important basis for nursing practice. One way of promoting such a way of practice is through phenomenological reflection and understanding from a practical perspective, “being able to manage something” (Heidegger, 1962, p. 183). Using a phenomenological way of ‘seeing’ allows a way of understanding how people manage being-in-the-world, whatever constitutes that world for them. At its more basic level it uncovers the world in which people exist and the level of interaction with their world. A phenomenological way of ‘seeing’ supports a perspective based on ‘the things themselves’, the heart of phenomenology.

The link between knowing pain and assessment is important for nursing in that it defines a partnership approach to the management of pain. It acknowledges the nurse’s experience and knowledge while elevating the person-in-pain to a level equal to that of the nurse. Historically, clinical knowledge especially in pain assessment and management, has been seen to be superior knowledge to that which the patient has. This study gives cause to re-think that approach and accepts the patients’ ways they know their own pain.

The model (figure 4) described in chapter six provides a basis from which an existential understanding of pain can be included in pain assessment and
hence pain management. The multidimensional factors discussed in chapter two that can contribute to, or result from, the experience of pain, and the factors that can contribute to a dissonance between the nurse’s view and the patient’s view of pain in effect gives cause to look again, existentially, at the person with pain. Knowing pain as an interacting unit of person, world, being-in-pain and cancer, may provide a better model for nurses, and diminish the incongruence that can exist between their understanding and the patient’s understanding. Looking again at the phenomenon of cancer pain from an additional perspective may be beneficial in uncovering the meaning of ‘subjective’ in the pain experience.

**Clinical applications**

Heidegger’s language and philosophy generally have been described as difficult although a practical dimension of his work has underpinned application of his philosophy to this study. Heidegger (1926/1962) was concerned with the meaning of Being and therefore the structures and dimensions within Being. Examining these factors has uncovered support for the place of the self within his philosophy, which has practical implications for nursing. Heidegger obviously felt the need to make his philosophy accessible in one way at least, and in a practical sense. Throughout his analysis he would illustrate a point with a very practical application.

Applying the process and outcomes of this study to nursing practice, two levels become obvious, the descriptive findings and the process or methodology. The findings, as illustrated above, are important at the individual level of patient care. Nursing and palliative care are underpinned by a philosophy very much concerned with the individual and care is tailored to meet individual needs. Findings from this study illustrate two
important functions of individualised care; avoiding assumptions about patients and their pain, especially those assumptions based on hearsay and lack of understanding; and, knowing who the patient is, in the context of the fullness of their existence as far as they are prepared to divulge this. Assumptions are usually made on the basis of pain assessment inaccuracies (Harrison, 1991) and form part of poor pain intervention strategies, (McCaffery & Beebe, 1989). Understanding the many ways a person knows his or her pain provides insight into the need for intervention.

Avoiding assumptions, and understanding the person being cared for, are fundamental to the basic philosophy of nursing care and also take on an ethical dimension in terms of doing good and not harming the patient. In addition to understanding the person, understanding and utilising the most effective process in assessment is equally important. Somerville's (1994) question [see chapter two] about why someone is left in pain has a profound meaning when properly examined. This study may contribute in some way to answering that question. The study findings identify that there is another dimension to pain that health professionals do not always comprehend. Whether this is because of the 'measurement mentality' that pain can be understood from Likert scales and tick boxes needs to be further researched, although current research discussed in chapter two would suggest that this is so.

A phenomenological approach to pain assessment is also consistent with the concept of compassion as a way of managing pain in a partnership with the person-in-pain, discussed in chapter two. This has been demonstrated by the understanding gained from each person, because in spending time with each person and being willing to listen to the meaning that pain had for each of them, they were able to convey a personal knowing that had not
previously been explored. In doing so, questions are also raised about how nurses should practice with skill and yet protect themselves from such intense relationships as this process indicates is necessary.

In addition to the implications for nursing practice of pain assessment processes, this study has identified that not all patients receiving palliative care have their pain relieved. This raises important issues for palliative care nursing, because it is often thought that palliative care can provide pain relief that cannot be achieved in other settings. It illustrates that is imperative to examine and re-evaluate people who remain in pain even though it is considered that medication and non-drug interventions are being used appropriately. Most of the patients, with the exception of Jack, were receiving opioids, adjuvant medication, TENS, heat applications, massage and physiotherapy as pain management strategies and yet they continued to experience pain. This study demonstrates the need to adopt a phenomenological approach to pain assessment in palliative care, in order to achieve a level of understanding about a person-in-pain that would otherwise remain silent. The process also relieves the nurse of having to ask the right question, but prompts her or him to adopt another perspective to uncover what remains silent. The results of this study provide evidence that a variety of assessment strategies are required and that a phenomenological assessment approach to the person-in-pain is essential.

At the process level, in using a phenomenological method this study has identified a means or vehicle whereby practice can be changed by accessing a different approach to ‘finding out about the patient’. It is essential that any process, which improves understanding of patients and/or their illness/health, offers nurses clear methods of how this new understanding might benefit patients from a nursing perspective. Phenomenology has been
successfully practised as discussed in chapter two by Rogers (1961) and Taylor (1994). Although Rogers is a psychologist, his practical experiences are resonant with the process used in this study. Rogers’s central hypothesis is that the potential of each person will be assisted within a relationship with a carer in which the carer is compassionate, with a deeply sensitive non-judgemental understanding. There is a profound similarity with this and the objectives of understanding and assessing patients in pain through phenomenology to determine the best way to assist them to manage their pain. Equally, Taylor was able to access this ‘phenomenological way of seeing’ in an oncology setting and which also resounds with success in practice.

Phenomenological practice has implications for nursing education because phenomenology is often taught particularly at postgraduate level, but with a view to engaging in research not practice. The issues arising from this study are not only that there are important implications for how pain is assessed by nurses in clinical settings but how to change current practices to better utilise the assessment process. As discussed in chapter two, education has had equivocal results in changing pain assessment and management practices. However, the studies identified that relate to practice outcomes have not always clearly identified the educational processes used. The education factor will be discussed later in the chapter.

Clinical application of this study focuses on the thematic and individual nature of the findings and the application of the methodology to practice, supporting both the philosophical underpinnings of nursing and palliative care. This will necessitate that the nurse listen to, and have a belief in, the patient as knower of their own pain. The practicality of this kind of assessment would not require the nurse to gain such a profound
understanding of another person within the first hour of their meeting. It would be accomplished over time with interventions as required on each occasion to address the issues the patient identified. The purpose of such an assessment would not be to take over from the patient the way they ‘manage’ their pain, but to assist them to reach their potential in Being-in-the-world-of-pain as suggested by Rogers (1961) and Taylor (1994). This is in part what intervention means in this context. It is also important that nurses be involved in this kind of assessment and not relinquish it to other members of a multidisciplinary team. Nurses are with the patient more than other members of the team; they have the best opportunities to develop a relationship with the patient; they have the opportunity to develop a sound knowledge of all aspects of pain; and they have the experience of all aspects of patient care, and so are ideally situated to work with patients-in-pain.

Cancer pain assessment means gaining an understanding of a person’s Being-in-the-world, who that person is in the world and where each is along the continuum of time. Using a process of looking for understanding of the phenomenon of knowing pain has the potential to overturn inaccuracies, misunderstandings and biases previously encountered. Such a way of assessment will require a different approach to education and organisational attitudes with further research to support it. This study also illustrates the need to examine what knowledge is valued in the clinical setting, what is documented in a meaningful way and the patient’s understanding of how intimate knowledge will be used. There is an underlying assumption in this thesis that people-in-pain will want to share their knowing so that it will assist with their pain assessment. However, this may not always be the case, and the sharing of knowledge brings with it responsibilities for the nurse to ensure people’s individual privacy concerns are addressed, which will have
implications for the way in which phenomenological knowledge is expressed and transmitted.

The results of this study, although they addressed people-with-cancer pain, have implications that reverberate across all nursing settings. The findings and the process used, make it easy to extrapolate to other areas of nursing and question what other benefits there would be for patients if nurses practised within a phenomenological framework and raises questions about the role of the nurse in all patients’ suffering. Given that suffering, with or without pain, is a phenomenon that nurses frequently come into contact with, it follows that nurses are situated to provide mechanisms to support people who are suffering, whether from physical, social, emotional or spiritual sources. This approach does not undermine a multidisciplinary perspective, which is becoming more evident particularly in palliative care, but rather it defines the role of the nurse within a team.

A NEW MODEL
The difficulties associated with cancer pain, its management and its assessment described in chapter two, fall within the relationship between the subjective nature of pain, the language of pain, assessment of pain and the pervasive nature of pain, illustrated in figure 1, chapter two. This model was extended (figure 4, chapter six) following analysis of the text to incorporate the ontological dimension of knowing pain. This is a useful model when adopting a process for working with and understanding the person who has cancer pain. The model provides a link to the practical application of the phenomenological approach to pain, and the Heideggerian concepts of Being and knowing described in chapter three. As a result of the understanding generated by the study, the themes identified in chapter
five and the assessment discussion in chapter six, a more comprehensive approach to pain management is possible.

The data generated to support this approach have been gathered from lengthy interviews, nevertheless, it is expected that a nurse experienced in working with people who have cancer pain, would be able to undertake a less time consuming process to understand the nature of the pain within the existence of the person. The length of the interaction with the person is not the key to understanding but rather the ability to learn from other people who know their pain better than anyone else does. Interpretation and synthesis are important elements in the process and in practice it is envisaged that understanding could be immediately validated with the person-in-pain.

The results of this study offer another way of approaching cancer pain assessment and although each person will have different meanings of their pain, it allows the themes identified to trigger a different approach to assessment. In operational terms it broadens the available resources that can be used to work with another person to help them control their pain and assists the nurse to ‘be with’ a person who is suffering. A philosophical perspective applied to practice will necessitate educational programs to support it and strong links between education and practice areas to ensure that nurses are developing the correct skills and that they are able to manage the intensity of the interactions that would be encountered at times.

**IMPLICATIONS FOR EDUCATION**

Having knowledge and understanding of another person’s pain is vital if there are to be better outcomes for people with pain. This study is one small step in achieving this. Nurses must be encouraged by those who provide
education, to be creative and innovative as well as practical and ‘scientific’, in the broad sense of the term, to further knowledge and understanding of pain. It is the nurse who is with the patient-in-pain and has the greatest opportunity to allow the primordial experience of pain to have a voice. This study is primarily concerned with the patient’s ways of knowing their pain, and the nurse’s role in incorporating that knowing within a holistic assessment.

The implications for nursing discussed above, raise issues of how ‘phenomenological seeing’ and better assessment practices can be achieved in nursing practice. It is suggested that targeted, innovative and creative teaching strategies that identify pain mechanisms, assessment tools and pain interventions and that also include an underlying ethical and phenomenological framework, may capture the imagination and intellect of nurses and result in better patient outcomes. Such educational programs would require research to validate any changes to outcomes in the clinical area. As discussed in chapter two, Heye and Goddard (1999) have put an ethical framework in place, although this program was not tailored to suit targeted groups of nurses. Despite the evaluations by pain educators and researchers such as Heye and Goodard (1999), McCaffery and Ferrell (1994, 1997) and Wilkinson (1991) education remains an important plank in achieving better pain assessment and management. However, it is not clear whether education strategies generally have been based on the research identifying barriers to pain assessment and management. It is suggested that by addressing the identified clinical problems with well-targeted education programs, better outcomes may be achieved.

Qualitative research that is often based on philosophical frameworks is seen as important for nursing and embraces the essence of nursing. I would therefore, argue that education in philosophy would be an advantage for
nurses. Such education, beginning at the undergraduate level, would better prepare nurses to undertake such philosophical research and presumably raise the standard of research. Such education would also have the advantage of promoting philosophical concepts in practice and defining a framework with which nurses understand a different perspective and are able to apply to their practice. As discussed above, the findings from this study have implications for all nursing, therefore, understanding and applying concepts such as persons and their relationship to the world would become an accepted way of nursing and open up new ways of working with, and valuing people. It would thereby provide nurses with an overall philosophical understanding within which they could make sense of the conflicts and tragedies with which they are often confronted and find another way of helping to achieve better outcomes for people. Education for nurses would also require the provision of strategies whereby nurses would be able to learn how to manage intense and open interactions with patients.

LIMITATIONS OF THE STUDY
Some of the limitations of the study were raised in chapter four regarding the difficulties of undertaking research with patients who are in the last stages of life. These difficulties impacted on access to people who would be able and willing to participate in the study and ultimately on the number of participants who did contribute to the study. Notwithstanding, the small number of participants contributed to the strength of the study because it allowed depth of understanding of the data.

The study answered the research question about the importance of ways of knowing pain in relation to pain assessment. The link that was made to
establish this relationship was found within the stories of the participants. Their stories highlighted times of obvious poor pain control at times and identified where better pain management strategies could be employed if the nursing and medical staff had the same understanding as was generated by the research. However, this connection would have been stronger if assessment strategies used by nurses at the time the study was conducted had been included in the research design. In this way actual assessments could have been used to support or disprove the findings in chapter six.

FURTHER RESEARCH
This study has examined assessment from the patient’s perspective. The nurse is the other part of the assessment process and therefore I believe this study should be extended, by examining the perspective of nurses in relation to pain assessment in palliative care. Some questions that need to be addressed include:

- What kinds of pain assessment are used in palliative care?
- How are assessments utilised in pain management strategies?
- How are patients re-assessed if they have poor pain outcomes?
- Are assessment processes concerned with the person-in-pain? And
- What are the impact and outcomes of the new model described in chapter six?

Given the findings of this study in relation to assessment, and the sometimes-poor pain outcomes for a number of the participants, the questions identified above would further extend understanding of such a complex process.
ETHICAL CONCERNS

Palliative care research has many difficulties including the nature of the patients researched and the burden the research may impose on them raising ethical questions. Ethical issues raised by this study and described in chapter four embrace the role of the nurse as advocate for the patient who is participating in research, and the issue of consent for patients who have a different sense of time because of their immediate way of Being-in-the-world. Madjar and Higgins (1996) have previously raised the issue of the inconsistencies within the area of consent with elderly patients, indicating the need for more debate in this area. My experiences encountered during this study reinforce the difficulties around consent. As a result of these experiences, I would support a structured process for consent even if it means that participants are lost to the study. Once structure and process are short-circuited to suit individual situations, then the potential exists for the rights of the participants to be compromised.

One of the difficulties I encountered, and also identified in chapter four was making the distinction between nurse and researcher. This issue has been canvassed in the nursing literature (Borbasi, 1994; Gardner, 1996) and although a middle ground is suggested, I often found this to be difficult, especially as I worked as a nurse providing care to some of the same patients with whom I was also a researcher at other times. Clearly, the patients saw me first as a nurse, if at all as a researcher. At times when patients specifically asked me to provide care during an interview, my response was to ask another nurse to assist the patient. However, at other times my responsibility to the patient dictated that I either complete the ‘session’ with them or not pursue their participation. These actions can be interpreted from the perspective of the ethical responsibilities of a researcher, however, reading my journal, my understanding is that these
decisions were made as a nurse. If the best outcomes for the patient are achieved, then does it matter? However, who then decides what are the best outcomes for the patient?

As a result of undertaking this study, I believe the issue of nurse or researcher will be a perennial one, because of the nature of the relationship between both. I suggest that the best way forward is to provide enough ethical guidance to nurse researchers so that they can make decisions that are not based on whether they are a nurse or a researcher, but on the needs of the patient or research participant.

ACHIEVING RIGOUR: AN OVERVIEW

The methods used in this study for achieving rigour have been discussed in chapters one, four, five and six. Achieving rigour is an essential component of qualitative research and in this study, relied on, subjective reflection in the form of a field journal; adequacy of description of the context; audit or decision trail; and adherence to the ontological philosophy of Heidegger in the conduct of the study and its analysis. In Heideggarian terms, the circle is complete when understanding and meaning of the phenomenon in question has been revealed. However, the process adopted in this endeavour is equally important, as has been argued previously. The process employed in this study not only ends with the explication of ways of knowing pain and its importance to assessment, but concludes in this chapter by associating Heideggarian concepts, the study results and nursing practice, through identifying the implications for nursing.
SUMMARY

This journey began with the question of ways of knowing cancer pain. It travelled on, unravelling the issues; the literature that discussed cancer pain, the problems with language, pervasiveness, individuality and assessment, and found each are intimately connected. It situated knowing within an ontological dimension and thus part of who we are as a person Being-in-the-world. The existential conversations became the point at which the journey turned back towards the beginning, uncovering everyday experiences that became the window of understanding the knowing of cancer pain and hence the meaning of cancer pain. The many structures uncovered have meaning within the ontological dimensions of Being-in-the-world, authenticity and temporality, providing the means through which each person has a relationship with the world of pain in which he or she lives. As a consequence it has important implications for how nurses approach a person-in-pain, across clinical, educational and research settings. Most importantly this study has added meaning to the ‘shadowy fraction’ of being-in-pain.
REFERENCES
REFERENCES


References 254


Royal College of Nursing, Australia (1999). Directory of Higher Education Nursing Courses - Registration and Postregistration. Royal College of Nursing, Australia, Canberra.


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PROJECT: Ways of Knowing Cancer Pain: An Important Factor in Assessment?

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This research project is being conducted by Joanne Ramadge a student from the School of Nursing at the University of Canberra.

The aim of the project is to investigate how the person with cancer pain can influence assessment of their pain by the ways they know and understand their pain.

It is expected that there will be one - two interviews, each lasting between thirty to ninety minutes, the time will be determined by yourself and the interviewer. A third interview may be requested later for matters of clarification. The interviews will be recorded on audio-tape and a written copy of what you say (interview transcript) will be made. The audio--tape will be erased and a copy of the transcript will be kept in a secure place. You will also be asked to keep a diary for a period of about two weeks describing your experiences of pain, the feelings, thoughts and physical responses associated with these experiences. The researcher only will know who you are and your identity will not be revealed to anyone else. The information you give may be used in reporting the findings of the research, and the findings may be published, but individual people will not be identified in any way.
If you agree to participate, you will be consenting to having the interviews recorded and used for research purposes. You may withdraw your consent at any time, and you do not have to answer questions about things you do not want to talk about. If you decide you do not want to continue with the research you can stop being involved at any time and you will not be disadvantaged in any way.

There may be no benefits to you in participating and the researcher understands that talking about your pain may be difficult. Your feelings will be respected.

If you want to talk about the project or ask questions about being a participant without incurring any obligations, you can contact Joanne Ramadge by telephoning 6231 5218 after four o'clock any day or 6252 8835(BH).

Thank you for considering this project.

Joanne Ramadge
APPENDIX B
RESEARCH CONSENT FORM

Project Title: Ways of Knowing Cancer Pain in a Palliative Care Setting.

Investigator: Joanne Ramadge

Contact: Joanne Ramadge
Ph: 252 8835 (Bh); 6231 5218(AH)

Purpose:
The purpose of this research project is to increase nurses' understanding of the ways patients know about their pain experiences and how this might influence assessment of their pain by nurses.

Process:
Interviews will be conducted approximately three times over a period of 3-4 weeks. Each interview will last between 30-90 minutes, depending on the needs of the person being interviewed. During these interviews, questions will be asked about your experiences with pain and these will be audio taped. You also will be asked to record in a diary, over a period of approximately two weeks, your feelings, thoughts and body responses when you have an episode of pain. Interview transcripts will be reviewed by academic staff at the University of Canberra for the purpose of evaluation of analysis.

Participant Rights:
You have the right to withdraw from the study at any time without any effect on your future treatment, to stop the interview, to refuse to answer any question at any time, or to question the researcher and such questions be answered to your satisfaction. There may be no direct benefit to the participants of this study but there may be more understanding and better assessment processes by nurses which may influence more appropriate treatment strategies for cancer pain.
**Researcher Responsibilities:**
Your name will not be associated with any of the information obtained and all recordings and written material will be stored securely and accessed only by the researcher. All tapes and diaries will either be returned to you or destroyed. The information will be used as part of a research thesis and may be published but your name will not be associated with the research.

You will have access to results and be asked to verify the analysis before the final report is written.

**Agreement:**
THIS IS TO CERTIFY THAT I,-----------------------------------------------

OF-----------------------------------------------

agree to participate as a volunteer in the above named project under the conditions described above. I understand and accept the conditions as outlined. I also understand if any difficulties arise which cannot be resolved then I may contact either the:

ACT Health Ethics Committee,
PO Box 825,
Canberra 2601
Telephone: 2050846

Signature:-----------------------------------------------
Date:-----------------------------------------------

---

Appendices 240
WAYS OF KNOWING CANCER PAIN IN A PALLIATIVE CARE SETTING

JOANNE RAMADGE

A THESIS SUBMITTED IN TOTAL FULFILMENT OF THE REQUIREMENT FOR THE DEGREE OF DOCTOR OF PHILOSOPHY

UNIVERSITY OF WESTERN SYDNEY
2001
PLEASE NOTE

The greatest amount of care has been taken while scanning this thesis,

and the best possible result has been obtained.
CERTIFICATE

The work for this thesis was begun at the University of Canberra and was completed at the University of Western Sydney following transfer that complied with all University regulations. I certify that this thesis entitled *Ways of Knowing Cancer Pain in a Palliative Care Setting* and submitted for the degree of Doctor of Philosophy, is the result of my own research, except where otherwise acknowledged, and that this thesis has not been submitted to any other university for any other degree.

Signature of Candidate

[Signature]

Date

9 July 2001
ACKNOWLEDGEMENTS

Dr Louise O’Brien for sharing her expertise, her very positive encouragement and her calm approach to life.

My colleague and friend Anne Just, for her caring support and invaluable advice.

The patients who gave their time and their stories.

My work colleagues and friends who have provided unending encouragement.
PHILOSOPHY

Philosophy means liberation from the two dimensions of routine, soaring above the well known, seeing it in new perspectives; arousing wonder and the wish to fly. Philosophy subverts man’s satisfaction with himself, exposes custom as a questionable dream, and offers not so much solutions as a different life.

A great deal of philosophy, including truly subtle and ingenious works, was not intended as an edifice for men to live in, safe from sun and wind, but as a challenge: don’t sleep on! there are so many vantage points, they change in flight. What matters is to leave off crawling in the dust.

Walter Kaufman
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ABSTRACT

Pain is a phenomenon that is complex and subjective. It implicates the physical, social, emotional, immunological, and spiritual aspects of being human. It has the power to reach the essence of human existence. Much research is focussed on the physiological, social, cultural, emotional and cognitive aspects of pain. However, very little work has been undertaken that explores pain as a part of human existence and the inherent knowing that accompanies it. This aspect of pain is fundamental to how a person-in-pain can exist with pain; it forms the ways a person knows their own pain. What pain means to people and how they know their own pain is the subject of this research study. The study sought to identify ways of knowing cancer pain of the six participants and the implications this holds for assessment of pain by nurses. Each of the six participants was receiving palliative care at the time of the study; a setting that provided a layer of complexity to the research process. Heideggerian hermeneutic phenomenology provided the framework for the study and the concept of knowing was explored within Heideggerian philosophy and applied to nursing assessment. An essential construct, the self as individual, which has formed the basis of much debate within nursing, was explored in relation to the universality of Being. Conversations and diaries provided data that informed thematic development of the shared meaning of Being, and contributed to assessment profiles formed within the construct of the self. The themes of, balancing conflict, living with threat, always there, and making sense are identified and examined to provide understanding of the ways these six people know their pain. The process of and themes from the study offer a stimulus to nurses to add another form of assessment to the range of assessment options available to them. A new model of pain assessment is offered that incorporates an ontological way of knowing, and the meaning that the findings have for nursing practice is explored. Implications for nursing practice and education that are derived from the study are offered. The rigour of the study is promoted through an audit process.