

University of Warwick institutional repository: <http://go.warwick.ac.uk/wrap>

A Thesis Submitted for the Degree of PhD at the University of Warwick

<http://go.warwick.ac.uk/wrap/47360>

This thesis is made available online and is protected by original copyright.

Please scroll down to view the document itself.

Please refer to the repository record for this item for information to help you to cite it. Our policy information is available from the repository home page.

“A pain that ruins mountains”: A case study of factors influencing postoperative pain management in two Jordanian hospitals

Mayada Daibes

A thesis submitted in partial fulfilment of the

Requirements for the degree of

Doctor of Philosophy in

Nursing

University of Warwick

School of Health and Social Studies

[July, 2011]

Chapters overview

Chapter 1: Literature Review

Section 1: Clinical research on factors influencing pain management

Section 2: Social research on clinical politics: Factors influencing clinical practices and interactions

Chapter 2: Jordan: An overview of the research setting

Chapter 3: Methodology and methods

Chapter 4: Is pain as issue among surgical patients? Pain prevalence scores and observations

Chapter 5: Individuals' relations

Section 1: Nurse-doctor relations

Section 2: Professional-patient relations

Chapter 6: The influence of contextual factors

Section 1: The influence of the socio-cultural context

Section 2: The influence of the organization

Chapter 7: Discussion and conclusion

Contents

List of boxes, Tables, Figures	viii
List of appendices	ix
Dedication.....	xi
Acknowledgments	xii
Declaration	xiv
Abstract	xv

INTRODUCTION

Background.....	1
Research aim and questions.....	1
Organization of the thesis.....	2

CHAPTER ONE: LITERATURE REVIEW

SECTION ONE: CLINICAL RESEARCH ON FACTORS INFLUENCING PAIN MANAGEMENT

Introduction.....	6
An overview: Pain prevalence among surgical patients is still an issue worldwide	6
Factors influencing pain and its management.....	9
1. Patient related factors	9
1.1 Patients' beliefs and attitudes.....	9
1.2 Patients' characteristics	11
2. Professional related factors.....	16
2.1 Professionals' skills and capabilities.....	17
2.2 Professionals' technical knowledge regarding pain management.....	20
2.3 Professionals' beliefs and attitudes regarding pain and its management	25
2.4 Nurses' personal biographical characteristics.....	27
3. Organizational factors.....	29
Concluding remarks	30

SECTION TWO: SOCIAL RESEARCH ON CLINICAL POLITICS_ FACTORS INFLUENCING CLINICAL PRACTICES AND INTERACTIONS

Introduction.....	32
1. Nurse-doctor relations.....	33
1.1 Nursing adoption of medical ways of knowing	39

1.2 Nurses' response to being marginalized: Docility and resistance	39
2. Professional-patient relations.....	41
2.1 Discursive interpretation and assessment of pain by professionals	43
2.2 Controlling the passing of knowledge from professionals to patients.....	44
2.3 Publicizing of subjective needs and complaints	45
2.4 Effect of the social hierarchies on patients' pain practices.....	45
3. Organization	46
3.1 Normalization	48
3.2 Hierarchical observation	49
3.3 Examination.....	51
4. Society.....	52
4.1 Gender socialization and stoical beliefs	52
4.2 Mass Media	54
Subject: Body and consciousness	55
Concluding remarks	58

CHAPTER TWO: JORDAN_ AN OVERVIEW OF THE RESEARCH SETTING

Introduction.....	60
1. Geographical overview	60
2. Demographic characteristics	61
3. A brief historical overview	62
4. Language in Jordan	63
5. Social structure-related issues and customs	64
5.1 Patriarchal family structure.....	65
5.2 Conservatism.....	66
5.3 Honour	67
5.4 Respect.....	69
5.5 Social visiting and hospitality	70
5.6 Use of personal influence (Wasta)	71
6. Overview of main health sectors in Jordan	72
6.1 The Governmental (public) health sector	73
6.2 Jordanian Royal Medical Services (JRMS)	74
6.3 Private health sector	74
6.4 Health workforce.....	74
Concluding remarks	75

CHAPTER THREE: METHODOLOGY AND METHODS

Introduction	77
1. The post-structural Foucauldian theory underpinning this study	77
2. Choice of qualitative research approach	81
3. Choice of qualitative case study and its design	82
3.1 Limitations of case studies	83
3.2 Assuring quality and rigour in carrying out the case studies	87
3.2.1 Triangulation.....	88
3.2.2 Respondents validation	89
3.2.3 Clarity of data collection methods and analysis	89
3.2.4 Attention to negative or disproving data	89
3.2.5 Relevance.....	90
4. Carrying out the case study	90
4.1 Pilot study.....	90
4.2 Obtaining ethical approval and access permission	92
4.2.1 First stage: Asking for ethical permission prior to upgrading	93
4.2.2 Second stage: Further unexpected hurdles to obtain access and ethical permission	95
4.3 Sampling.....	97
4.3.1 Hospitals	98
4.3.2 Universities	100
4.3.3 Participants	101
4.4 Contacting potential participants of case studies	104
4.5 Challenges related to the process of obtaining Consent	107
4.6 Data collection methods	112
4.6.1 Non-participant observations.....	112
4.6.2 Informal interviews.....	118
4.6.3 Semi-structured interviews	119
• Planning the interview structure and themes.....	122
• Pain scales used: Numerical Rating Scale (NRS)	123
4.6.4 Document review	124
4.7 The Language of the research	126
4.8 Preparing data for analysis.....	126
4.8.1 Transcription.....	126
4.8.2 Translation	128
4.8.3 Preserving anonymity in reporting findings.....	128
4.9 Data analysis	130
4.9.1 Debates regarding when to initiate analysis	132

4.9.2 Simple quantification.....	133
4.10 Reflexivity.....	134
4.10.1 Scrutiny and rigour of the knowledge produced	134
4.10.2 Maintenance of ethical practice and principles throughout the research process.....	137
4.10.3 Helps the researcher to identify their position from their own values systems, others' values, and from study findings	138
4.11 Positionality.....	138
4.11.1 Insider and outsider.....	138
A. Professional background and educational level	139
B. Nurse-researcher dual identity	141
C. Gender	142
D. Being 'native'	144
5. Methodological standpoints.....	145
5.1 Reflecting on Foucault's insights with regards the research methodology and the chosen data collection methods	146
Concluding remarks	147

FINDINGS

CHAPTER FOUR: IS PAIN AN ISSUE AMONG SURGICAL PATIENTS? Pain prevalence scores and observations

Introduction.....	149
1. Issues related to utilizing NRS among Jordanian surgical patients.....	149
2. Pain prevalence among patients who could score their pain.....	152
Concluding remarks	157

CHAPTER FIVE

SECTION ONE: NURSE-DOCTOR RELATIONS

Introduction.....	159
1. Lack of nurse-doctor discussion about postoperative pain	159
2. Nurses in the position of being 'disciplined' and/or 'docile'	167
3. Nurses in position of resistance to domination- marginalization by doctors	171
4. Public views of both nursing and medicine: Reinforcing the nurse-doctor hierarchical relations.....	174
Concluding remarks	179

SECTION TWO: PROFESSIONAL-PATIENT RELATIONS

Introduction	181
1. Relationship between professionals' pain knowledge and pain assessment practices.....	181
2. Forms of nursing practices that embodied patients' marginalization	188
3. Forms of nurses' disciplinary actions.....	193
4. Patients' resistance to the professionals' actions.....	199
Concluding remarks	203

CHAPTER SIX

SECTION ONE: THE INFLUENCE OF THE SOCIO-CULTURAL CONTEXT

Introduction	206
1. The effect of socio-cultural context through "sexual surveillance"	206
1.1 Nurses' pain management practices with patients of the same gender	217
1.2 Inappropriate delegation: Another form of nurses' subordination to socio-cultural context	219
2. Influence of sexual surveillance on patient practices	221
3. The extension of the patriarchal position of males into Jordanian hospitals.....	223
4. Social-familial traditions in supporting hospitalized surgical patients: Visitation	230
5. The use of personal influence (<i>Wasta</i>)	235
Concluding remarks	238

SECTION TWO: THE INFLUENCE OF THE ORGANIZATION

Introduction	240
1. Organizational disciplinary power: Displaying hierarchical observations.....	240
2. Organizational disciplinary power: Fear of punishment.....	243
3. Role of organization in reinforcing nursing subordination	245
4. Role of organization in marginalizing pain management from staff's work.....	248
5. Staffing levels, workload, and the shifts schedule.....	250
6. The effect of social hierarchies	252
7. Influence of the structural layout of the ward	255
Concluding remarks	256

CHAPTER SEVEN: DISCUSSION AND CONCLUSION

Introduction	258
I. Nurses and patients' practices in pain management postoperatively	259

1. Nurses' practices.....	259
2. Patients' practices.....	262
II. Nursing practices: A poststructuralist reading of nursing pain practices in the studied hospitals	262
1. Disciplinary power: Role of organization	264
2. Disciplinary power: Role of socio-cultural context	269
2.1 Gender relations and "sexual surveillance"	270
2.2 The extension of the patriarchal position of males into Jordanian hospitals	273
2.3 Gendered power relations or strong power relations among participants of different genders?	276
2.4 Public view of nurses: Further impacts on professionalism.....	280
III. Nursing knowledge: How do nurses construct their knowledge regarding pain?	281
1. Formal learning: Theoretical knowledge	282
2. Interacting with other professionals in daily working life: Practical knowledge of roles and boundaries.....	285
3. Foreground knowledge.....	286
IV. Potential factors influencing patients' practices in postoperative pain management process	288
1. Patients' practices in light of the socio-cultural context.....	288
1.1 Sexual surveillance	289
1.1.1 Visitation customs: Reinforcement of sexual Surveillance.....	291
1.2 Stoicism	292
1.2.1 Stoicism, and Masculinity and patriarchy.....	293
1.2.2 Stoicism as a response to nurses' disciplinary practices	295
1.2.3 Cultural governmentality through non-governmental institutions: the effect of mass media.....	296
1.3 Violent practice as a form of resistance	297
V. Use of personal influence (<i>Wasta</i>)	300
VI. The influence of space	301
Conclusion	303
Limitations and reflections on study theory and setting.....	306
Significance and contribution of the study	308
Recommendations.....	310
Concluding remarks	313
References	314
Appendices	338

Boxes, Tables and Figures

Boxes

Box (1): Definition of practices related to the use of personal influence (<i>wasta</i>)	71
Box (2): Key amendments asked by the committee of research ethics in JMoH	94
Box (3): Key reasons to select the two studied hospitals	99
Box (4): Key points discussed with heads of departments and nurses during the preliminary visits.....	105
Box (5): Actions made in response to needs in the field	136
Box (6): Indicators of pain that professionals relied on to assess patients' pain	182
Box (7): Characteristics patients used to describe nurses.....	201

Tables

Table (1): Number and gender of participating patients.....	101
Table (2): Numbers and characteristic of participating nurses	102
Table (3): Number of participating surgeons in each hospital	103
Table (4): Gender of participating relatives in both hospitals	104
Table (5): The hours of shifts at both hospitals.....	115
Table (6): Number of participants who accepted or rejected digital tape recording of interviews in both hospitals.....	127
Table (7): Number and percentage of patients who could/could not rank pain and distress severity	151
Table (8): Frequency of pain scores at time of interviews (1 st , 2 nd , 3 rd day postoperatively).....	153
Table (9): Mean of nurses' numbers to patients on different shifts	250

Figures

Figure (1): Map of Jordan and nearby countries	61
Figure (2): Percentage of beds each health sector make up of the total number of hospital beds in Jordan	74
Figure (3): Examples of citations of quoted strips of raw data collected by observations and interviews	129
Figure (4): Frequency of pain scores among patients at day zero postoperatively	152
Figure (5): Mean number of visitors of different patients during different observation episodes in both hospitals	231
Figure (6): Mean number of patients and nurses on different shifts.....	251

Appendices

Appendix One: Key searching terms used to review literature.....	339
Appendix Two (A): Letter from the Dean of Nursing School where the researcher worked, to the Dean of Nursing School in the governmental university.....	341
Appendix Two (A.1): Letter from the Dean of Nursing School in the Governmental University to the Head of IRB in the same University.....	342
Appendix Two (A.1.1): Letter from the Head of the IRB in the Governmental University granting ethical and access permission.....	343
Appendix Two (B): Letter from the Dean of Nursing school in the Private University to the Head of the IRB in the Private University	344
Appendix Two (B.1): Letter from the Dean of the Nursing School in the Private University confirming the ethical and access permission granted from the Head of the IRB in the same University.....	345
Appendix Two (C): Letter from the Dean of the Nursing School in the Private University, where the researcher is an employee, to the Minister of Health asking for ethical and access permission to the Public Hospital.....	346
Appendix Two (C.1): Letter from the Ministry of Health forwarded to the manager of the Public hospital confirming granting to the researcher the requested ethical and access permission to the Public Hospital.....	347
Appendix Two (C.1.1): Letter from the manager of the Public hospital to the researcher confirming granting the ethical and access permission upon the agreement of the internal committee of ethics and the Ministry of Health.....	348
Appendix Two (D): Letter from the Dean of Nursing School, where the researcher is an employee, to the Higher Command of the Royal Medical Services, Jordan, requesting ethical and access permission to the Military Hospital.....	349
Appendix Two (D.1): Letter from the Higher Command of the Royal Medical Services, Jordan, confirming granting ethical and access permission to the Military Hospital.....	350
Appendix Three (A): Information letter and consent form (Patients- Arabic Version).....	351
Appendix Three (A.1): Information letter and consent form (Patients- English Version).....	355
Appendix Three (A.1.1): Informed consent form nominated by the JMoH to be used for research purposes when inviting patients to participate in research.....	359
Appendix Three (B): Information letter and consent form (Staff Nurses- Arabic Version).....	360
Appendix Three (B.1): Information Letter and consent form (Staff Nurses-English	

version).....	364
Appendix Three (C): Information letter and consent form (Relatives-Arabic version).....	368
Appendix Three (C.1): Information letter and consent form (Relatives-English version).....	372
Appendix Three (D): Information letter and consent form (Physicians-English version only).....	376
Appendix Four: Sample of poster stuck on patients' beds, doors of patients' rooms clarifying that an observation is in progress.....	380
Appendix Five: The researcher's access card to the military hospital, clarifying the beginning and ending dates of the research, and the extension for a month.....	381
Appendix Six: Sample of sheets used for recording observation notes.....	382
Appendix Seven: Themes of topic guides of all participants interviews.....	383
Appendix Eight (A): Interview topic guide (Patients).....	385
Appendix Eight (B): Interview topic guide (Staff nurses).....	388
Appendix Eight (C): Interview topic guide (Physicians).....	392
Appendix Eight (D): Interview topic guide (Relatives).....	395
Appendix Nine (A): Structural Layout: Surgical Male Ward, Hospital (X).....	396
Appendix Nine (B): Structural Layout: Surgical Female Ward, Hospital (X).....	397
Appendix Ten: Table of newspaper reports about incidents of physical violence against health professionals.....	398

Dedication

“My Lord! Grant me the power and ability that I may be grateful for Your Favours which You have bestowed on me and on my parents, and that I may do righteous good deeds that will please You, and admit me by Your Mercy among Your righteous slaves.”

Al-Naml (27:19)

To my family in gratitude for their support and inspiration.

Acknowledgements

This research would not have been possible without the immense help and support of my supervisors: Prof. Kate Seers and Dr. Loraine Blaxter.

Dr. Loraine Blaxter mentored me and was generous with her time, effort, advice and knowledge throughout my studies in the United Kingdom. I would like to thank her for teaching me how to think critically, and for the reassurance that big things can be achieved step by step.

Many thanks must also go to Prof. Kate Seers, who allowed me much of her time and the benefit of her wide knowledge and expertise, and provided much fruitful feedback on my work. I am particularly grateful to Prof. Seers for showing me that, in this world, there are still people who have faith in nursing and are passionate about improving its future.

These two generous ladies were the biggest advocates of this research and each spent time and effort supporting me with the construction of this thesis.

Many thanks go to Dr. Arwa Owies who believed in my potential, and nominated me for a PhD scholarship from the sponsoring university. Further thanks go also to Dr. Fadia Hasna who has supported me throughout my professional and academic career.

Acknowledgement must be made of the contribution to this work made by the nursing and medical staff and patients in both studied hospitals. Their generosity with both time and information enriched this research considerably.

On a personal note I wish to thank my friends in the United Kingdom for their encouragement, and to acknowledge the support of staff and students of the School of Health and Social Studies, the university library, and the University of Warwick graduate school. Thanks must also be offered to the University of Warwick itself for granting me the honour of being one of its students.

All of these people, and others who are not named here, provided me with constant support and motivation and enabled me to apply the passion and fervour that this thesis required and deserved. I offer my sincere thanks.

Finally, I would thank planet Earth for inhaling all of the CO₂ produced by the long periods I spent at my computer and on the internet. Thank you for the trees that were cut and made into the thousands of sheets of paper I used during the last four years, and in my whole academic life. Thank you for the rainy, wet, cloudy, romantic weather that has always inspired me to sit and write. Thank you.

Thank you all

Mayada Daibes

Declaration

I am aware of university regulations governing plagiarism and I declare that this work, which is being submitted for university assessment, is all my own work except where I have stated otherwise, and has not been submitted for any other degree at another university.

Signed: Mayada Daibes

Date: / / 2011

Abstract

Postoperative pain is still poorly managed among surgical patients despite evidence-based approaches to its treatment being well established. Prompted by the persistence of this problem, many researchers have studied factors influencing postoperative pain management. Empirical clinical research has dominated this area and has presented a set of factors which, albeit important, have not taken into account the influence of contextual factors on the individual's practices in pain management.

This study is designed to examine the role of context on the practices and interactions of professionals and patients during postoperative pain management. Informed by the insights of post-structuralism, it uses non-participant observation, informal and semi-structured interviews with participants of both genders (29 staff nurses, 13 surgeons, 38 patients, and 20 patients' family members), and a document review to construct a case study of four surgical patients' wards in two Jordanian hospitals. Also included is a descriptive analysis of pain and distress scores, and a thematic analysis of the raw data

The findings reveal both a significant problem with pain among Jordanian surgical patients, and limited engagement by nurses in postoperative pain management. It is found that a series of socio-cultural and organizational factors limit participants' practices in respect of pain management. Influential socio-cultural factors include: sexual surveillance, an inferior public view of nurses, patriarchal ideas, and use of personal influence (*wasta*). Organisational factors include: hierarchical observations, fear of punishment, the subordination of nursing staff, perceptions of low staffing and high workload, and social hierarchies, such as rank. In combination these contextual factors operate as a set of disciplinary and power mechanisms that limit the ability of nurses to become involved in patients' pain management; impede nursing professionalism by restricting autonomy and self-regulation; reduce some of the patients' willingness to communicate pain and lead to a reluctance to be cared for by professionals of a different gender.

It is concluded that in this area organisational policies are subservient to nurses' culturally constructed approaches to pain management. As such, socio-cultural factors appeared to have a greater effect than organizational factors.

Recommendations are made to address the situation and provide for appropriate pain relief after surgery.

Introduction

Background

The initial motivation behind this research arose from an incident that left me temporarily hospitalized in one of the Jordanian hospitals, where I experienced severe pain. This incident, for me, was full of moments and events that had great consequences for personal change and development, and led me to reflect profoundly on my values as a nurse, especially in relation to the reduction of patient suffering. As a nurse, I believe that optimal management of pain is both a patient's "fundamental human right" (Brennan, Carr, & Cousins, 2007: 205) and a professional's duty. Although this thesis is not a personal account of my experience of pain, the events and the multiple incidents that took place during my hospitalization episode motivated me during the following years to study pain and related issues.

A review of research literature confirmed my own experience that pain is not well controlled after surgery and suggested that this has been the situation for a long period of time. This confirmed my belief in the importance of studying factors that influence pain management.

Research aim and questions

This thesis reports research that aims to examine and analyse the factors which influence the practices and interactions of professionals and patients in pain management. The research considers specifically the influence of the organizational and societal contexts in surgical settings in two Jordanian hospitals.

The following five research questions guided both data collection and analysis:

1. What do nurses do to assess, manage, and document patients' postoperative pain?
2. What factors influence nurses' assessment, interventions, and documentation practices in postoperative pain management?
3. What factors influence patients' practices in the postoperative pain management process?
4. What are the influences of the Jordanian context on postoperative pain management?
5. What is the influence of the organizational context on pain management?

Organization of the thesis

The work is presented in seven chapters. Chapter One is a literature review, and consists of two sections. Section One, 'Clinical research on factors influencing pain management', draws on clinical research that has analysed factors considered relevant to the pain management process and includes a discussion that illuminates the limitations of this literature. This section argues that the clinical approach needs to be complemented by an examination of social factors.

Section Two extends from this conclusion by using social research conducted on clinical politics to shed light on factors that influence clinical practices and interactions in health settings. This section contains a

discussion that shows how social research contributes to this thesis, and introduces briefly the theoretical framework which underpins the work.

Chapter Two, 'Jordan: An overview of the research setting', begins by describing the situation in Jordan with a focus on the social system, and the setting of those traditions and norms which showed a marked effect on participants' practices in this research. It also describes gender relations in Jordanian society as the situation here was of particular significance to participating patients, relatives, and professional staff, and had a large effect on their practices and attitudes. Finally, descriptions are provided of the main health sectors in Jordan and the situation as regards access to care, as well as an outline of the education and qualifications of nurses and other hospital staff.

Chapter Three, 'Methodology and methods', provides a detailed description of my journey in undertaking this research. It summarizes my epistemological and ontological perspective and methodology; presents a rationale for selecting the qualitative case study design, and explains the methods used to collect and analyse data. This chapter also shows how theory influenced my thinking.

Findings of the research are presented in chapters Four, Five and Six. Chapter Four, 'Is pain an issue among surgical patients? Preview of pain prevalence scores and observations', presents the findings related to pain scores in a simple quantitative analysis. It also provides a qualitative analysis of pain incidents through observations and interviews. This chapter

shows that postoperative pain was experienced by patients as a problem in both studied hospitals.

In chapters Five and Six, I use Foucauldian theoretical insights to analyse power relations between different participants in specific contexts.

Chapter Five has two sections. Section One, ‘nurse-doctor relations’, introduces findings related to the influence of the nurse-doctor relations on pain management practices. The clinical setting in both studied hospitals as a political arena is discussed.

Section Two of Chapter Five, ‘Professional-patient relations’, shows the position of professionals and patients in relation to each other and introduces findings on the postoperative practices of both patients and nurses. This section also presents data on power techniques and resistance within these practices, and more importantly their effect on pain management.

Chapter Six presents findings on the effect of contextual factors. Chapter Six has two sections. Section one, ‘The influence of the socio-cultural context’, presents findings demonstrating how the socio-cultural context constructs patients and professionals’ ‘subjectivities’ (practices and attitudes) in relation to pain management. It considers in particular societal mechanisms of constructing the desired and accepted actions of people.

Section Two of Chapter Six, ‘The influence of the organization’, shows the effect of hospitals as organizations on professionals’ practices, particularly the practices of nurses. This chapter shows that hospitals work as dynamic

apparatuses rather than rigid structures by embedding counter discourses in their spaces as well as through exerting power over participants.

Finally, Chapter Seven, 'Discussion and conclusion', discusses the main themes of the findings, placing them within the context of the related literature. This chapter takes up the main findings from previous chapters and exposes them to further theoretical discussion, drawing toward a section of conclusion and recommendations. This chapter also explores the limitations of the work as a whole and outlines its original contribution to knowledge.

Section One

Clinical research on factors influencing pain management

Introduction

This section highlights the issue of postoperative pain prevalence among surgical patients worldwide, and reviews the literature that has investigated factors which influence the pain management process and its outcomes.

For the literature review, a search (English language only) was conducted in databases, such as Pubmed, Medline, and Cumulative Index to Nursing and Allied Health Literature (CINAHL Ovid and EBSCO), for Mesh terms. A search for free texts was made in other databases, such as Web of Knowledge and ASSIA, and some search engines, such as Google Scholar. In addition, a hand search for key searching words of interest was conducted (Appendix One). Studies were screened and the full text of those relevant retrieved. The references of lists of the retrieved texts were then searched.

An overview: pain prevalence among surgical patients is still an issue worldwide

Although postoperative pain is one of the expected consequences of almost all surgery, ineffectively controlled postoperative pain can lead to potentially serious complications that impact on recovery, rehabilitation and patients' quality of life. Inadequate management of pain may lead to pathophysiological complications (Griffiths & Justin, 2006; Haljamae &

Stomberg, 2003; Haung, Cunningham, & Laurito, 2001), which include atelectasis, pneumonia, nausea and vomiting. Under-managed pain may also lead to an altered metabolic response, which can lead to delayed recovery (Al Samaraee, Rhind, Saleh, & Bhattacharya, 2010). It can also have adverse psychological consequences (Rollman, Abdel-Shaheed, Gillespie, & Jones, 2004), such as depression. In addition, 'poor pain' control has been shown to prolong the hospital stay, increase morbidity, and can contribute to the development of a chronic pain state (Al Samaraee *et al.*, 2010: Abstract).

Despite efforts to avoid such consequences, and despite now well established advances in evidence-based pain management techniques (Bandolier, 2007; McQuay & Moore, 1998), inadequate pain management is still common (Apfelbaum, Chen, Metha, & Gan, 2003), and the majority of research studies agree that postoperative pain is an issue among hospitalized patients across time and in different setting.

The problem of postoperative pain has been discussed for a considerable period of time. Reports on unrelieved postoperative pain can be found as early as the 1950s (Papper, Brodie, & Rovenstine, 1952), and similar reports have continued to appear in more recent literature. Studies conducted during the 1980s reported high pain prevalence among hospitalized patients. For example, the prevalence of pain among patients who reported experiencing pain during hospitalization was recorded at 100% (n= 353), of whom 58% reported 'excruciating pain' (Donovan, Dillon, & McGuire, 1987: 73). Studies conducted in the 1990s showed no reduction in pain prevalence

among patients and was also reported to be 100% (n= 74) by Puntillo & Weiss (1994), and 79% (n=205) by Yates *et al.* (1998).

Similarly, studies conducted in the first decade of the 21st Century showed little improvement in pain prevalence, and reported that at least half of patients still experience pain postoperatively (Gramke *et al.*, 2007; Coll & Ameen, 2006; Girard *et al.*, 2006; Watt-Watson, Chung, Chan, & McGillion, 2004; Svensson, Sjostrom, & Haljamae, 2001;)

Not only is the prevalence of pain reported to be high among surgical patients, but also its intensity. For example in a study to examine patients' postoperative pain experience and the status of acute pain management in the United States, Apfelbaum, *et al.* (2003) reported that about 86% of 250 patients reported moderate to extreme pain postoperatively. Gelinas (2007) also reported that about 50% of 93 cardiac surgical patients experienced moderate and severe pain postoperatively. High intensity patient pain has also been reported by many other recent studies worldwide (Buyukyilmaz & Asti, 2010; Maier *et al.*, 2010; Sommer *et al.*, 2009; Sommer *et al.*, 2008; Gramke, *et al.*, 2007). Very recently, Wadensten, Frojd, Swenne, Gordh, & Gunningberg (2011) reported that about 42% of patients, both surgical and non-surgical, reported experiencing pain of severity >7 on an 11-point Numerical Rating Scale (NRS).

It can therefore be concluded that the available literature suggests that neither postoperative pain prevalence, nor reported pain intensity has improved substantially over several decades. It is clearly necessary to investigate the situation further and attempt to understand why pain

management is failing, in the hope that this may provide some explanation for the continuing high levels of postoperative pain, and suggest ways of improving its management.

To these ends, the following subsections introduce the existing clinical research on the factors which influence pain management.

Factors influencing pain and its management

There are many factors that influence pain management which are reported in the literature. These factors can be subdivided into three broad areas: patients, health professionals, and the organization related factors.

1. Patient related factors

The research identified many patient-related factors which influence pain management, including their beliefs, attitudes and issue relating to communicating pain, as well as their personal characteristics.

1.1 Patients' beliefs and attitudes

Research in this area has often focused on the attitudes and concerns of patients to the use of pain relieving medication. Concerns regarding the side effects of painkillers, especially addiction, are more frequently reported among cancer patients than surgical patients, and this may explain why less of the research found concerned surgical patients. Less frequent concerns regarding painkiller addiction among surgical patients might be attributed to their relatively shorter stay in hospitals compared to cancer patients (Greer, Dalton, Carlson, & Youngblood, 2001). Nonetheless, the available research on surgical patients suggests that many do fear addiction to painkillers

during hospitalization (Mangione & Crowley-Matoka, 2008; Fielding, 1994), despite the fact that opioid induced addiction during hospitalization occurs in less than 1% of patients (Clarke *et al.*, 1996).

It is important to consider these concerns among surgical patients due to the potential impact such fears may have on patients' willingness to report their pain to professionals. As many researchers reported, patients who report pain to health professionals are more likely to receive pain relief than those who do not report it or wait for pain relief to be offered (Winefield, Katsikitis, Hart, & Rounsefell, 1990). In their study of 61 post elective cholecystectomy patients, Winefield *et al.* (1990) reported that patients who believed in the possibility of addiction to painkillers were more reluctant to ask for pain relief. Tzeng, Chou, & Lin (2006) also found that patients were unwilling to report their pain due to fear of addiction and consequently received less painkillers, specifically those prescribed on a *Pro Re Nata* (PRN) (as needed) basis. Thus, higher pain intensities were reported among patients who hesitated to use analgesics, or hesitated to report their pain during the first three days postoperatively.

Fear of addiction among patients might be ascribed to many reasons, such as lack of patients' preoperative education, or low educational level (Kastanias, Denny, Robinson, Sabo, & Snaith, 2009). In an experimental study by Greer *et al.* (2001), 11% of 787 patients expressed fear of addiction preoperatively. This was reduced by half when an educational programme was initiated.

Patients' communication of pain might also be influenced by a belief that the 'good patients do not report their pain' as Ward *et al.* (1993: 319) reported. They found that 45% of 270 patients agreed that 'good patients' do not complain about pain, and argued that this explains why some professionals might have underestimated patients' experience of pain. Paice, Toy, & Shott (1998) reported that 25% of patients out of a convenience sample (n=200) reported being concerned with bothering nurses, and were reluctant to report pain to their nurses because they wanted to appear as 'good' patients. Similarly, patients in a study for Tzeng *et al.* (2006) confirmed that they hesitated to report pain to professionals to avoid distracting them from their work.

While the reviewed clinical research shows how erroneous beliefs such as these can create reluctance among some patients to report pain to professionals, a lack of discussion regarding the origin of such beliefs was noticeable in the clinical literature. It seems that patients' beliefs were studied in a societal and organizational vacuum, marginalizing the role of both these contexts and failing to consider a potential role of professionals in reinforcing or constructing such beliefs among patients.

1.2 Patients' characteristics

Characteristics of patients, such as gender (Pool, Schwegler, Theodore, & Fuchs, 2007; Bendelow, 1993), sex-related variables (Aloisi, 2003), age (Aubrun, Salvi, Coriat, & Riou, 2005); emotions (Bendelow & Williams, 1995), ethnicity and culture (Rahim-Williams *et al.*, 2007), self-efficacy (Motl, Konopack, Hu, & McAuley, 2006; Rokke, Fleming-Ficek, Siemens,

& Hegstad, 2004), mental illnesses (Jochum *et al.*, 2006; Dickens, McGowan, & Dale, 2003), and socioeconomic status (Brekke, Hjortdahl, & Kvien, 2002; Brekke, Hjortdahl, Thelle, & Kvien, 1999), were examined for their influence on patients' perceptions, tolerance, and threshold of pain¹.

However, there is less literature on the influence patients' characteristics have on their own and professionals' practices in pain management postoperatively. The literature focused primarily on the effect of patient's age, gender, and ethnicity, with some further work reporting the influence of patients' socio-economic status on professionals' decisions and practices.

- **Age:** Studies, such as McCaffery & Ferrell (1991), Calderone (1990), and Faherty & Grier (1984) all reported that age of patients has an influence on nurses' expectations of patients' pain and their decisions regarding pain assessment and management. For example, McCaffery & Ferrell (1991) reported that 359 nurses showed more willingness to believe older patients' subjective reports of pain than younger patients' reports. Horbury *et al.* (2005: 23) supported this finding in a study that reported that nurses were more likely to accept the self-report of older 'grimacing' patients than younger 'grimacing' patients. However, McCaffery & Ferrell (1991) found that nurses' willingness to believe older patients' pain reports was not reflected in their approach to the administration of painkillers. Their work reported that the majority of nurses, although more likely to believe older patients' reports of pain than those of younger patients, tended to increase

¹ For further comprehensive review of literature and discussion in this regard, see Daibes (2008).

the given dose of painkillers for young adults but not for older patients when the last dose had been ineffective.

A potential explanation for the incongruence between the beliefs and actions of nurses in McCaffery & Ferrell (1991), are concerns regarding respiratory depression among older patients. This explanation seems particularly plausible in light of findings from other studies, such as Closs (1996: 241), which reported that nurses had revealed 'exaggerated' concerns regarding opioid induced respiratory depression among older patients.

- **Gender:** Other researchers have studied the effect of patients' gender on professionals' practices. Although such studies are few and inconsistent, the available research studies suggest a gender bias, suggesting that professionals give fewer painkillers to women and believe them to complain more.

In a relatively old study into the administration of pain-killing medications, Cohen (1980) found that nurses who chose to manage pain with the lowest possible dose of medication or by placebo, were significantly more likely to do this when caring for female patients. Faherty & Grier (1984) also found that, for all age groups, nurses administered significantly lower doses of narcotics to female patients than to male patients. More recent studies, such as Calderone (1990) and McDonald (1994) have supported these findings.

Patients' gender was also reported to influence professionals' views of the frequency with which patients complained of pain. Foss & Sundby (2003) conducting a qualitative study that utilized unstructured interviews, found that professionals of different roles viewed female patients as more

demanding than male patients. For example, doctors described older female patients, in particular, as ‘demanding’, while nursing staff used the same word to describe younger women (Foss & Sundby, 2003: 45).

It should be noted however that in emergency settings findings regarding the effect of patients’ gender on professionals’ practices did not support those reviewed above. For example, Lord *et al.* (2009) studied the cases of 3357 patients, and reported that the gender of the patient had no significant influence on the rate at which professionals administered painkillers. These findings were also supported by Safdar *et al.* (2009). Lord *et al.* (2009) did however report that patients’ gender significantly influenced the type of painkiller administered, with male patients more likely to receive morphine than female patients.

It seems reasonable to conclude from these findings that patients’ gender has the potential to influence professionals’ pain management practices, however further investigation is required to confirm the significance of such effect in surgical settings.

- **Ethnicity:** Some researchers have examined a potential relationship between patients’ ethnicity and professionals’ pain management practices. The majority of the studies in this area were conducted in Emergency Departments (ED) in the United States of America (USA).

Work here suggests the existence of a racial bias, as in most studies white patients were given more analgesics than patients of other ethnicities. For example works conducted in the USA by both Todd *et al.* (2000) and

Pletcher, *et al.* (2008) demonstrate that white patients received significantly more analgesics compared to black patients with similar complaints of pain. Pletcher and colleagues showed further that black patients were the least likely to receive opioids than other examined ethnic groups, including Hispanics and Asians, but that these groups also received fewer analgesics than white patients.

A review of literature by Epps *et al.* (2008) of research also conducted in the USA, supported Pletcher *et al.* (2008) and reported that Hispanics were twice as likely to receive no pain medication when treated in EDs in comparison with non-Hispanic patients with similar conditions.

However, some research, especially that which takes into account other variables, such as behavioural indicators and facial expressions, revealed the opposite findings. For example, Burgess *et al.* (2008: 1852), in a study conducted in the USA, reported that patients' race and verbal or non-verbal behaviours influenced physicians' decisions to prescribe strong opioids. For example, patients who were black and angry were given stronger doses of opioids than white patients who showed the same behaviours.

Studies that considered clinicians' gender also showed different findings. For example, Weisse *et al.* (2001) reported that male physicians prescribed more analgesics to white patients with renal colic, but female physicians prescribed more analgesics to black patients.

In conclusion, research suggests that patients' ethnicity might have an influence on health professionals' pain practices, but findings are inconsistent.

- **Socio-economic status:** Fewer researchers have studied the influence of patients' socio-economic status on practice, thus relatively few studies could be found in this area (Wilson, 2009; McCaffery, Ferrell, & O'Neil-Page, 1992). The research that does exist suggests that nurses are more willing to believe the level of pain reported by patients of higher socio-economic status, and more likely to underestimate unemployed patients' report of severe or moderate pain. They also found that nurses expressed a greater reluctance to provide PRN painkillers to patients of lower socio-economic status.

In summary, research suggests that patients' characteristics may influence professionals' pain management decisions. Findings in this regard are however inconsistent and there is a lack of research reports about the influence of such characteristics.

The studies reviewed so far, while important, are insufficient to understand why the pain management process has undergone little improvement. Thus, the next subsection will focus on studies that examined professional factors.

2. Professional related factors

Many studies examined the influence of nursing skills and competencies on the pain management process. Other studies have investigated factors that might influence these practices, such as nurses' technical knowledge, their attitudes and beliefs regarding pain and its management, and finally, their personal characteristics.

2.1 Professionals' skills and capabilities

Studies here often reported ineffective and inadequate pain management practices, and nurses were often blamed for these problems. Different practices in pain management, including assessment, interventions, and documentation practices have been studied.

Inadequate assessment of patients' postoperative pain by nurses, whether at rest or in movement, was reported (Ene, Nordberg, Bergh, Johansson, & Sjostrom, 2008; Manias, Botti, & Bucknall, 2002). Manias *et al.* (2002) reported that nurses ignored pain assessment early during patient activities such as walking postoperatively or when moving patients for certain procedures. In other studies, nurses tended to continue with an activity or procedure even when patients complained of pain, saying that the movement or procedure was necessary and should be completed (Manias *et al.*, 2002).

A lack of pain assessment using pain scales was also highlighted (Shugarman *et al.*, 2010). Many pain scales, such as Face Pain Scale-Revised (FPS-R) and NRS have been demonstrated to be reliable and valid. For example, Gagliese, Weizblit, Ellis, & Chan (2005), showed that NRS has high reliability and validity in comparison with other pain scales such as VAS, and FPS-R among young and older patients. NRS and FPS-R also showed high sensitivity for pain intensity in old surgical patients in a study for Herr and Chen (2009). In Von Baeyer *et al.* (2009), NRS was also noted for its easy use among patients of all age groups.

Despite this, many researchers reported that the use of pain scales is minimal among hospitalized patients. Wadensten *et al.* (2011) reported that about 40% of 494 patients who reported pain had not been asked to self-assess their pain using a formal pain scale, such as NRS.

In addition to inadequate use of pain scales, nurses often underestimated pain (Shugarman *et al.*, 2010; Kappesser, Williams, & Prkachin, 2006) although underestimating patient's pain can have negative effects if appropriate treatment is withheld (Davoudi, Afsharzadeh, Mohammadalizadeh, & Haghdost, 2008).

The majority of studies showed that nurses have a greater tendency to underestimate patients' pain than to overestimate it (Davoudi *et al.*, 2008). In a study to compare patients and nurses' ratings of patients' pain, Davoudi and colleagues found that the mean scores of nurses rating of pain were significantly lower than their patients' ratings. Overestimations of the level of pain experienced occurred among 12.4% of situations studied, far less than the 27.6% of nurses who underestimated pain. These results supported earlier studies, such as research of Sloman *et al.* (2005), and Idvall, Berg, Unosson, & Brudin (2005). Thus, much of the research recommends the use of pain scales to assess pain as they help patients to accurately express their pain intensity (Wadensten, *et al.*, 2011), rather than leave this consideration to the professionals' estimation.

In some studies, nurses relied on patients' appearance and facial expressions to assess and verify their pain reports (Kaki, Daghistani, & Msabeh, 2009; Sjostrom, Haljamae, Dahlgren, & Lindstrom, 1997), and to administer doses

of analgesics (Horbury *et al.*, 2005). Moreover, in a study by Twycross (2007), nurses neither used pain assessment tools with any regularity, nor did they take behavioural or physiological indicators of pain into consideration, but administered painkillers only when patients complained of pain. This suggests that unless patients complained of pain, nurses made no formal assessment of the patients' needs for analgesia.

The reassessment practices of nurses were also investigated in many studies, and many reported inadequate pain reassessment and check-up after administering painkillers (Bucknall, Manias, & Botti, 2007; Briggs & Dean, 1998; Tittle & McMillan, 1994). Bucknall *et al.* (2007) observed 52 nurses caring for 364 patients in two surgical units in a major metropolitan hospital and found that out of 316 pain activities observed in 74 observation episodes, only 4% (about 14) were reassessed after analgesic administration. Mostly, nurses reassessed pain and the effect of painkillers by chance and only during medication rounds, but rarely carried out specific reassessment. Bucknall and colleagues found that when reassessing pain nurses used wide vague questions such as 'Are you Ok?', which were often unhelpful for patients to give answers regarding their pain complaints.

A possible explanation for the lack of assessment and reassessment practices is the lack of organizational policies, as Brockopp *et al.*, (1998) suggested. However, in some hospitals in Sweden where a mandatory structured follow up is required, it was found that only 84% of nurses used standardized questionnaire 1-2 days postoperatively to assess patients pain (Stomberg, Segerdahl, Rawal, Jakobsson, & Brattwall, 2008). This suggests

that the presence of mandatory pain assessment policies would not necessarily ensure that all nurses would use the suggested tools, but it might well increase the use of them.

The inadequacy of nursing documentation of pain assessment and management interventions was also reported in many studies (Idvall & Ehrenberg, 2002; Briggs & Dean, 1998). Briggs & Dean (1998) reviewed patients' records and applied content analysis to nursing documentations. They found that nurses' assessments of pain were poorly documented. While only 34% of patients' records reported that patients had pain, about 91% of interviewed patients, whose records were reviewed, said that they had experienced pain.

Dalton *et al.* (2001) supported these findings and reported, upon reviewing patients' profiles, that the minimal documented data in patients' charts reflected the minimal pain assessment and management activities.

The majority of studies reported inadequate pain assessment, reassessment, and documentation practices by nurses. However, insufficient explanation was provided for the prevalence of such inadequate practices.

2.2 Professionals' technical knowledge regarding pain management

This is another factor investigated for its potential effect on pain management practices. Many studies reported professionals' lack of knowledge, in particular regarding the pharmacological aspects of pain management. These findings were consistent for many countries around the world and have been observed over a considerable period of time.

Both Hamilton & Edgar (1992), and Van Niekerk & Martin (2001) reported that inadequate knowledge regarding painkillers and their side effects, such as addiction, ceiling effect, and respiratory depression was dominant among nurses in acute care hospitals in Canada and Australia.

Other studies, such as Lui, So, & Fong (2008) in Hong Kong, Salvador-Hernandez *et al.* (2009) in Spain, and Kaki *et al.* (2009) in Saudi Arabia, presented a picture which was no better, and reported a lack of knowledge among nurses regarding the pharmacological aspects of medical and acute surgical pain management.

Inadequate knowledge, as well as beliefs about opioid induced addiction and respiratory depression has also been reported among physicians (Messerli, Abeti, Guidi, & Simonetti, 2008; Zanolin *et al.*, 2007; Visentin, Trentin, De Marco, & Zanolin, 2001). However, when comparing the knowledge of groups of nurses and doctors, there was a significant statistical difference in the knowledge scores, with nurses scoring much lower than doctors.

Reasons for the reported lack of knowledge among professionals varied between several research studies. Some studies found hospitals to be providing inadequate information to staff (Van Niekerk & Martin, 2001). Akbas and Oztunc (2008) reported that 88% (n=198, mean of 12 years experience) of nurses had not received education about pain outside nursing school and did not read about pain in journals. Other researchers, such as Horbury *et al.* (2005), found that organizations provided education in this area but that nurses show poor attendance at such in-service sessions.

Another group of researchers identified inadequacies in university education and syllabuses as potential reasons for a lack of knowledge and understanding of pain management (Rahimi-Madiseh, Tavakol, & Dennick, 2010; Goodrich, 2006; Plaisance & Logan, 2006; Chiu, Trinca, Lim, & Tuazon, 2003; Ferrell, McGuire, & Donovan, 1993).

For these studies to be properly considered however, it is necessary to evaluate whether professionals' knowledge actually influences their practical approach to pain management.

Wolfert *et al.* (2010) found that 23% of 216 physicians thought that addiction is defined purely by physiological characteristics, such as physical dependence or withdrawal symptoms and tolerance, and only 19% correctly defined addiction as a compulsive use of harm. Interestingly, doctors who prescribed opioids frequently were those who defined addiction correctly in terms of behavioural characteristics. This suggests that lack of knowledge regarding painkiller addiction might impact on the physicians' opioid prescription practices. This finding echoes Marks and Sachar (1973), who reported that 73% of patients who reported pain were under-treated because of physicians' concerns about opioids induced addiction.

The above findings of the study by Wolfert *et al.* (2010) do not seem to support findings of a study conducted earlier by Watt-Watson *et al.* (2001). While Watt-Watson *et al.* (2001) found that there are many misbeliefs and a knowledge deficit about pain management among all participating nurses (n=94), and that only 47% of patients were given their recommended doses of painkillers. Their research also reported that nurses' knowledge scores

were not significantly related to their patients' pain ratings or the analgesics administered. This suggests that even if nurses' knowledge scores are high, this alone is insufficient to improve pain management.

This in part seems to support the findings of other studies which examined the effect of nurses' educational level on their practices. For example, Hamers *et al.* (1997) found that the higher education level of nursing staff did not influence their pain management practices, but that practical experience did have an influence. Latimer *et al.* (2009) showed that nurses' level of pain knowledge, education level, or access to education had no effect on their pain management practices.

The above review shows that there has been an effort to study the influence of inadequate knowledge on professionals' pain management practices. It was frequently concluded that health professionals are responsible for inadequate pain management because of lack of knowledge and that an improvement of knowledge regarding pain management might decrease patients' ratings of pain. There is however some limited, but important, evidence that even when nurses have good knowledge, pain scores do not necessarily improve (Watt-Watson *et al.*, 2001).

There is a notable gap in the reviewed literature regarding the effect of professionals' background knowledge on their pain management practices. Most of the studies examine the influence of technical or 'foreground knowledge' (May, 1992: 473), on nurses' pain management practices, while researchers ignored the 'background knowledge' (May, 1992: 473), or 'social background' knowledge (Fagerhaugh & Strauss, 1977: 23)

professionals had of their patients. The professionals' foreground knowledge can be considered to be that "which establishes the clinical definition of the body" (May, 1992: 473), and therefore considers the patient as a case more than as a human with experience. However, the professional's background knowledge "establishes the patient as an idiosyncratic and private subject, and opens this up as an appropriate focus of nurses' work" (May, 1992: 473).

Nurses and other health professionals may have a limited knowledge of aspects of a patients' social background, and biographical data, and thus, such considerations are often not a focus of professionals' concern in their work with patients (Fagerhaugh & Strauss, 1977). The importance of having this knowledge is that a patients' background might influence their beliefs, practices, and interactions with staff in the hospital, (Fagerhaugh & Strauss, 1977).

In addition, in the literature, much attention is focused on tools to examine professionals' technical knowledge and attitudes to pain management (Akbas & Oztunc, 2008; Ferrell & McCaffery, 2008; Visentin *et al.*, 2001; Watt-Watson *et al.*, 2001; Tanabe, Buschmann, Forest, & Forest, 2000; McCaffery & Ferrell, 1997; Hamilton & Edgar, 1992; Watt-Watson, 1987), but there is little focus on attempts to assess staff knowledge regarding their patients' backgrounds and variables relevant to pain and its management.

A third gap found in this area of the literature is that all of the studies, without exception, examined either the quantity or the quality of nurses' knowledge, or both, but did not consider the 'type' of taught knowledge.

May (1995: 170) argues that the ‘type’, not the quantity or the quality of nurses’ knowledge influences their position in the power relations with doctors and therefore the extent to which they can apply alternative forms of legitimate knowledge and interventions (Chapter One; Section Two; Subsection 1). May argues that the type of knowledge that doctors acquire through their training enables them to observe, analyze and evaluate a patient’s problem and upon that, to decide what is most suitable for that particular patient. Further discussion on this gap is introduced in Section Two of this chapter.

2.3 Professionals’ beliefs and attitudes regarding pain and its management

Several studies reported that some nurses had negative attitudes towards certain aspects of pain management, such as the use of painkillers or opioids (Broekmans, Vanderschueren, Morlion, Kumar, & Evers, 2004). These attitudes ranged from a reluctance to provide painkillers because of a belief that patients over-report their pain (Harper, Ersser, & Gobbi, 2007; Van Niekerk & Martin, 2001), to an attitude that any patient who complains of pain should first be provided with a placebo to verify whether they are genuinely in pain (Messerli *et al.*, 2008; Visentin *et al.*, 2001).

Lack of knowledge, especially regarding pharmacological approaches, could be the origin of such conceptions and attitudes. Given that research into the effects of knowledge on professionals’ pain is inconsistent and inconclusive, as presented above, it is necessary to question the extent to which professionals’ attitudes particularly offer a reasonable explanation for their

ineffective pain management. Several studies have investigated the connection between the attitudes of nurses and their actions. For example, Lui, So, & Fong (2008) investigated pain management in medical units in Hong Kong and found that nurses' attitudes were not significantly associated with their practices. Although nurses in this study had reported appropriate attitudes towards pain management, a discrepancy between their attitudes and practices in pain management was identified (Lui *et al.*, 2008). Although 71% of 143 nurses said in advance that the most accurate judges of pain intensity are the patients themselves, the same nurses, when later asked to read two vignettes, said that they believed complaints of pain from a patient who showed expressions of discomfort over those from a patient who did not display discomfort. This suggested that there is a discrepancy between what nurses say they believe and the way they act when assessing patients' pain.

In two other studies by Twycross (2008) and Young, Horton, & Davidhizar (2006), it was found that nurses generally held positive attitudes about the use of pain management tools, but that these attitudes were insufficient to prompt nurses to use such tools in their practice. Twycross (2008) compared the results of a questionnaire which aimed to measure the importance attributed by nurses to pain management tasks, and the tasks nurses actually carried out. It was found that nurses' attitudes to the importance of pain management tasks did not affect the likelihood of those tasks being undertaken. For example, while 8 out of 12 participating nurses rated the use of pain assessment tools as 'highly critical', the majority of nurses did

not use pain assessment tools in their practice. Furthermore, only three nurses were observed carrying out reassessment of pain, despite the fact that all nurses rated reassessment as highly critical in the questionnaire. In addition, although ten nurses rated nursing documentation of pain intensity scores of 'moderate to high critical' importance, only three nurses documented pain scores regularly and others did it very rarely. Thus, Twycross (2008) concluded that nurses' attitudes to pain management tasks do not influence the way nurses apply such tasks on the ground.

In investigating such discrepancies between attitudes and practices, Young, Horton, & Davidhizar (2006) explained that nurses were aware of the importance of some aspects of pain management, such as using assessment tools, but for some reason failed to act as they knew they should.

These 'reasons' (Young *et al* 2006), or 'forces' as Clabo (2008) referred to them, were not actually discussed in most of the clinical literature. Further discussion of this will be introduced in Section Two of this chapter.

In summary, studies revealed a discrepancy between nurses' attitudes to pain and their practices of pain management. Evidence of the effect nurses' attitudes have on effective pain management is limited and the studies that do exist are inconclusive and fail to investigate certain reasons behind these attitudes. Further information, therefore, is required here.

2.4 Nurses' personal biographical characteristics

Less research exists examining the relation between nurses' personal characteristics, such as years of experience, and personal experiences of

pain, on their pain management practices. However, the research which does exist, and similar to studies reviewed earlier, offers inconsistent findings regarding such influences. For example, Lui, So, & Fong (2008) and Harrison (1991), found that nurses with greater experience more accurately assessed patients' pain, and were more capable of applying and integrating their knowledge in practice. However, Choiniere *et al.* (1990) reported that many experienced nurses underestimated their patients' pain and therefore managed it insufficiently, and this was in contrast to new nursing staff who were more likely to overestimate their patients' pain. Sjostrom *et al.* (1997) supported Choiniere and reported that nurses with greater experience underestimated patients' experience of pain. Other researchers such as Hamers *et al.*, (1997), and Dudley & Holm (1984) found that length of experience had little effect on nurses' pain practices.

Some researchers have investigated the effect nurses' personal experiences of pain have on their attitudes and practices. For example, Ketovuori (1987) reported that nurses without personal experience of pain had overestimated patients' pain and were more sympathetic to their patients' pain than those who had experienced pain. However, some other researchers reported that nurses who had experienced pain themselves were more likely to overestimate their patients' pain (Holm, Cohen, Dudas, Medema, & Allen, 1989).

Other nurses' characteristics, such as age, cultural background, and job satisfaction were less frequently investigated. They were examined in a

relatively old study by Dudley and Holm (1984), and showed no influence on nurses' pain management practices.

The literature review highlights the inadequate practices of nurses in respect of pain management. As mentioned previously nurses are often blamed for ineffective pain management because of their inadequate practices or characteristics. Studies have examined the influence of many factors on nurses' practices, such as knowledge and education, attitudes, and personal characteristics. However, the presented studies gave inconsistent evidence of any relationship between these factors and nurses' practices in pain management, and further studies are therefore needed to explain nurses' practices in pain management, and the factors that influence them.

In this regard, a few studies have attempted to view the issue of ineffective pain management in the context of organization.

3. Organizational factors

Organizational factors reported in clinical literature as influencing pain management practices, and consequently pain management outcomes, can be separated into two categories: shortage of nursing staff and workload, and organizational policies and structures.

Schafheutle, Cantrill, & Noyce (2001) reported that workload and staff shortages were the most frequent problems mentioned by nurses asked about barriers to effective pain management. Willson's (2000) observational study found that, in addition to the lack of knowledge, factors related to time

limited nurses' practices and decisions, especially in respect of administering analgesics.

In a report on the work of Rejeh *et al.* (2009), it was stated that nurses in Iranian surgical wards are responsible for the care of several patients; and often, there is little time for individual assessment, or for the reassessment of the effect of administered painkillers.

Phillips (2000) stated that nurses encountered restrictions on their actions through regulations on the administration of opioids. Although these policies are designated to prevent addiction and illicit use (Johnson, 1998), many researchers such as Schafheutle *et al.* (2001), reported that such policies have impacted on managing patient pain by preventing nurses from administering such drugs without the presence of an eye witness. Wolfert *et al.* (2010) found that many physicians in the USA were concerned regarding the inspections done on their prescribing practices, and they addressed this by decreasing the prescribed opioid doses.

Nevertheless, the research does not offer a comprehensive study of some organizational-related factors, such as organizational culture, on staff practices and attitudes. This will be examined in the next section.

Concluding remarks

Studies that examine the factors that influence the pain management process often blame both patients and nurses for unimproved pain management outcomes. However, the findings of those investigations that sought to establish the effect of influencing factors are inconsistent and there is insufficient study of the wider factors that might influence the practice of

both patients and professionals. Organization and society, as well as the interaction of individuals, play a potential role in the construction of practices and attitudes. It is therefore necessary to turn to the social research and develop an understanding of other factors that might influence clinical practices and interactions. The next section draws on studies from the works of Foucault, feminist poststructuralist, anthropologists, and historical reports, to develop ideas about how these factors influence the clinical processes within clinical contexts.

Section Two

Social research on clinical politics: Factors influencing clinical practices and interactions

Introduction

In the previous section, a review of clinical research revealed that postoperative pain remains an issue among surgical patients. It was shown that there are many studies available which investigate factors influencing pain management, and introduce explanations for persistent high pain prevalence among surgical patients worldwide. The research reviewed often highlighted the role of nurses, suggesting problems with lack of knowledge, unhelpful attitudes, inadequate practices, and speculating that several biographical characteristics can also play a role. It was further shown that organizational factors, such as policies and staff shortages can impede effective pain management. It must be acknowledged however that, while clearly important, these studies do not present consistent findings regarding factors influencing pain management, and furthermore do not focus on contextual issues such as Johansson, Hamberg, Westman, & Lindgren, (1999) note.

Social research investigates more extensively factors which influence relationships in clinical settings, and the effect of organization and society in constructing people's practices and attitudes in general. However, there is

little social research that specifically focuses on pain management, while the research which does exist on the topic provides limited empirical evidence about its influence on patients and professionals' practices and attitudes to pain management postoperatively. This section illuminates the current understanding of the influence of contextual factors on human behaviours in general, and applies these discussions to build an argument about the potential effect such factors may have on practices and interactions in pain management in hospitals.

A review of those areas of social research potentially relevant to practices and attitudes in hospitals examined four main areas of inquiry:

- Factors related to individuals' social relations:
 1. Nurse-doctor relations.
 2. Professional-patient relations
- Contextual factors:
 3. Organizational factors
 4. Socio-cultural factors

1. Nurse-doctor relations

Nurses and doctors are the professionals primarily responsible for patients' care. However, despite this shared responsibility it can be argued that nurses and doctors are members of different discourses, and therefore tend toward different views of the patient's body.

'Discourses', according to Foucault (1972), are ways of thinking, or of producing knowledge and meaning. They "constitute the nature of the body, unconscious and conscious mind and emotional life of the subjects which

they seek to govern,” (Weedon, 1987: 108). Through discursive knowledge, these discourses construct individuals’ actions or ‘discursive practices’ (Foucault, 1972), and provide ‘positions’ for individuals to take up (Gavey, 1989). These positions influence a person’s authority and their ability to apply their knowledge in the presence of people of other discourses. The capacity of someone to implement and apply their knowledge and the related discursive practices is therefore highly determined by the extent of power of positions they are granted by their discourse (Gavey, 1989).

Foucault (1994, 1980) argued that power and knowledge are strongly related, and that discursive knowledge is a determinant of power, and consequently a determinant of an individuals’ position in their relationships. In addition, given that strong discourses have both firm institutional (Weedon, 1987) and societal bases (Cheek & Porter, 1997), an individual’s position in their relationships is shown to be influenced by gender, status, and the power of their discourse in their societies (Reeves, Nelson, & Zwarenstein, 2008; Zelek & Phillips, 2003; Gjerberg & Kjolsrod, 2001; Cummings, 1995; Doering, 1992).

Historically, medical knowledge has been dominant in clinical settings (Freidson, 1970; Stein, 1967), while nursing knowledge has often been marginalised or even subjugated. This hierarchical structure of knowledge further supported doctors’ power, and also defined the position of other health professionals (Kenny & Adamson, 1992).

The dominant position of medical knowledge in this hierarchy has evolved historically with the adoption of the biomedical model, which mainly acknowledges biophysical knowledge about the patient’s body and disease

(Stein-Parbury & Liaschenko, 2007; Campbell-heider & Pollock, 1987).

The achievements of biomedical knowledge during the era of infectious diseases has shaped both the modern consciousness and contemporary public views of medicine, developing a belief that medical knowledge ‘can cure anything’ (Tellis-nayak & Tellis-nayak, 1984: 1064). This view, especially among the public, gave further power and authority to medicine and to doctors as medical practitioners, often at the expense of nursing and nurses (Cheek & Porter, 1997).

Medical power has been reinforced not only by the type of knowledge - in this case, biophysical knowledge (May, 1995) - but also by the ways in which this knowledge has been gained, or, in other words, ways of knowing. For Foucault (1975) the way of obtaining knowledge, rather than the knowledge itself, is what produces power and accordingly authority and dominance. The powerful knowledge of a doctor has been produced through ‘a penetrative form of observation’ (Henderson, 1994: 936), or as Foucault (1975: 149) originally termed it ‘gaze’. *Gaze*, which is discussed extensively in Foucault’s work *The Birth of The Clinic* (1975), is a source of medical ‘mathematical’ and ‘sensory’ knowledge of the body, that views people as a collection of signs and observable indicators, and then analyzes and labels them (Foucault, 1975: 149). The power of the *gaze* is embodied in its ability to reduce the human body to a collection of signs and indicators that can be observed, touched, heard, and recorded (i.e. can be measured through the senses), and, more importantly, can be analysed; placing the body in a weak situation by removing it from the subjective identity that

constitutes both the individual's power and uniqueness. *Gaze* deals with all bodies in the same manner, making them visible and knowable simply by noticing and analysing taught signs. It recognises only the body signs removing an individual's opportunity to utilize their own language to express complaints. Or as Foucault put it more eloquently: by *gaze*, "the definition of ... a linguistic structure of the real is reduced to praise of the immediate sensibility" (Foucault, 1975: 149).

It is worth mentioning that *gaze* as Foucault described it is different from simple surveillance, observation, or monitoring. Foucault's *gaze* refers to a form of penetrative surveillance that includes collecting data, analysing and evaluating it, and then making decisions based upon that analysis. Simple observation, as Dougherty (1999) described it, is a form of data collection not followed by analysis and decision making. Thus, gaze within this study will take both meanings, and the Foucauldian *gaze* will be written in *italics*.

It is also worth noting that the distinction between ways of knowing of nurses and doctors is not always clear. In his works, especially *The Birth of The Clinic*, Foucault did not provide the same account of the ways of knowing, and thus power, of nurses as he did of doctors. Other researchers such as Carper (1978), have described aspects of nurses' knowing as arising from an understanding of the patient's body holistically: considered aesthetically, ethically and personally.

Understanding of the position of nurses in their relations to doctors is important because nurses' knowledge, and accordingly practice, can be

significantly influenced by the dominance of medical power (Doering, 1992).

Nurses continuously perceive and are exposed to the 'legitimate' doctors' knowledge in daily work life. Thus, nurses, in some studies, had modified their discursive practices and observation to legitimate their knowledge (Manias & Street, 2001b), ignoring those other ways of knowing which define the patient's body holistically.

Henderson (1994) showed that nurses in Intensive Care Units (ICU) extracted their knowledge through practising a '*clinical gaze*' in their work with patients. ICU nurses, as Henderson wrote, often focus on the objective signs of patients, utilize and produce the same type of objective knowledge that ICU doctors have about patients. Henderson argues that for this reason ICU nurses enjoy more legitimated power than nurses in other departments.

Given that learning from doctors and adopting their medical practices might be productive behaviours, the adoption of doctors' skills and learning by nurses might be considered a form of resistance to their subordinate position in power relations. However, some nurses seemed to internalize their subordinate positions and produce negative non-productive behaviours (Hodes & van Crombrugghe, 1990), such as acting 'docile' (Manias & Street, 2001b: 132), accepting doctors' agency.

Manias and Street (2001b) reported that, because of their subordinate position in the hospital hierarchy and in the nurse-doctor relations, some nurses call on doctors for everything, showing a fear of engaging independently with even the slightest patient complaint. This served to

marginalize both their own knowledge and the expertise of their colleagues. This finding corresponds with the study of Campbell-Heider & Pollock (1987) which reported that the subordinate position of nurses in relation to doctors, both in hospitals and society in general, encourages the idea that only a doctor can diagnose a patient's complaints, and thus produces dependent behaviours. These two studies demonstrate a Foucauldian insight into the power system: 'interiorization'. Interiorization is the internalizing of the effects of disciplinary measures or the practices of dominant parties, and their expression in an individual's self practices (Foucault, 1980). Results of interiorization might be 'docility' or 'resistance', or both depending on an individual's position in relations with others. However, the question remains: how might the asymmetrical nurse-doctor power relation play a role in pain management?

My response to this question will examine two of the main themes of the previous discussion, it will focus on:

- 1.1 Nursing adoption of medical ways of knowing, such as observation.
- 1.2 The subjugation or sidelining of nurses' knowledge, and consequently, influence of nurses' response to such subjugation and exclusion.

Although these points were discussed above, the following subsections will seek to establish how this discussion can be linked specifically to pain management.

1.1 Nursing adoption of medical ways of knowing

Pain is a highly subjective phenomenon that cannot be measured by indicators and is often hard to assess. Relying on signs and observed indicators may increase the suffering of patients who do not show these when experiencing pain. On the other hand, pain management, as well as other clinical processes reliant on patients' self reporting may be hindered if nurses do not engage with patients to enable subjective reporting of pain. Thus, reliance on observation without further involvement and understanding of patients' background variables might lead professionals to miss patients' complaints, and also might, as Henderson (1994) argued, impact on the 'meaningful' nurse-patient relations by "reduc[ing] the power of the nurse in relation to the traditional role of *caring*" (p. 938). This is because, as Henderson argued, adopting doctors' ways of knowing by some nurses is to promote the communication which almost all doctors, but few patients, consider it meaningful.

1.2 Nurses' response to being marginalized: Docility and resistance

Despite spending greater lengths of time with patients, allowing nurses to develop a better understanding of their patients' complaints, many studies have shown that the hierarchical nurse-doctor relations often results in a marginalization of this knowledge (Daiski, 2004; Coombs, 2003; Manias & Street, 2001a). The failure of doctors to include nurses in discussion and to benefit from their knowledge of patients, e.g. during the ward rounds, impedes "the flow of information on which the material practice of nursing

work depends,” (May, 1992: 475). Consequently, nurses find it more difficult to apply their practical skills effectively, and this obvious lack of knowledge damages patients’ confidence in them. (May, 1992). It can therefore be seen that whether nurses respond to marginalization by docility or resistance, the result of a lack of discussion of pain care between doctors and nurses is not to the benefit of the patient in pain (see Chapter five: Section one: Subsection 1). In MacKay, Matsuno, & Mulligan (1991), the level of communication and discussion between nurses and doctors was identified as a powerful determinant of the quality of care that nurses provided to patients. In a further study by Niekerk and Martin (2003), about 63% of 1015 nurses reported feelings of marginalization. It was suggested that poor cooperation and communication between nurses and doctors had impeded the participation of nurses in the decision making process, forming a barrier to the provision of optimal pain management and impairing the effective communication of patient care-related issues.

In conclusion it has been shown that the nurse-doctor relation has the potential to influence pain management through ineffective communication, and through certain nurse behaviours produced by their hierarchical relationship with doctors. However, the nurse-doctor relation is just one aspect of the many relations that take place in clinical settings. The next subsection introduces a discussion of the literature on the potential influence of the professionals-patient relations.

2. Professional-patient relations

The empirical clinical studies reviewed in Section One of Chapter One explored some of the patient characteristics which influence pain management practices. In addition to the reluctance of some patients to communicate their pain, many studies reduced patient related factors to concrete, technical explanations, such as patients' lack of knowledge, or concerns, such as the fear of addiction. Other studies referred to non-modifiable factors such as patients' age, gender, and ethnicity.

Although these studies are important, they do not take into account patients' status and position in relation to health professionals as potential factors that may influence both parties' practices in pain management.

The available social literature provides a wide consensus that the professional-patient relation is asymmetrical in terms of power (Grimen, 2009). Patients are often weaker or vulnerable in their relationship with professionals for several reasons. They may be vulnerable because of their health status (Johnson & Webb, 1995). Patients may lack the ability to impose preferences and values; to make autonomous decisions; and to benefit from information offered to them when they are ill, under stress, or distracted by pain (Grimen, 2009).

Foucault's insights into power, especially his fundamental assertion that power is always present in relations between individuals, are particularly relevant in a discussion of professional-patient relations. The clinical literature showed a clear lack of discussion regarding power in health

settings generally (Grimen, 2009), and in professional-patient relations in pain management specifically.

For health professionals, the expertise and specialized knowledge which is a factor Foucault argues intimately related to the origins of power, are the main cause of their dominance in their relations with patients (Holmes, Prron, & Savoie, 2006; Sinivaara, Suominen, Routasalo, & Hupli, 2004; Kettunen, Poskiparta, & Gerlander, 2002).

The paradox is that the knowledge which makes professionals powerful and dominant is in part produced by patients (Holmes *et al.*, 2006; Kettunen *et al.*, 2002). That is, when patients are open to providing information about themselves and their subjective experiences to professionals, with no reciprocity in ‘confession’, they become vulnerable, making professionals more knowledgeable about their cases and more capable of judging and labelling them (Holmes *et al.*, 2006: 3).

Still the question is: How might asymmetrical professional-patient power relations influence clinical processes including pain management.

Four main themes in Foucault’s works and subsequent social research offer some ideas regarding the role of the asymmetric professional-patient relations here. These themes are:

- 2.1 Discursive interpretation and assessment of pain by professionals.
- 2.2 Controlling the passing of knowledge from professionals to patients.
- 2.3 The normalizing and publicizing of pain or other felt needs and subjective complaints.
- 2.4 Effect of the professional status on patients’ pain practices.

2.1 Discursive interpretation and assessment of pain by professionals

Professionals might exercise power in clinical settings verbally (Sinivaara, *et al.*, 2004) or non-verbally, through their daily practices, and discursive interpretations. The patient's subjective report of pain is considered the golden standard in pain assessment, as reflected by McCaffery's (1979) definition of pain as "whatever the experiencing person says it is, existing whenever he says it does" (p: 14). However, patients' reports of pain are often interpreted by professionals who rely on their discourses and knowledge to understand what a patient communicates (Price & Cheek, 1996), and this is a possible explanation for the incongruence displayed by the pain reports of patients and nurses in many clinical studies. Professionals who rely on observation to assess pain might underestimate a patient's report of pain if such an evaluation is not accompanied by observable indicators, such as facial or behavioural expressions, or abnormal vital signs. This implies that the patient, in turn, needs to legitimate pain by making it more detectable, by, for example, crying or screaming, (Fagerhaugh and Strauss 1977). However, social beliefs and attitudes in some societies might prevent patients from displaying such behaviours which would otherwise have legitimated their pain in the eyes of professionals (Chapter One, Section Two, Subsection 4.1), and patients might therefore experience pain silently, potentially hindering assessment.

2.2 Controlling the passing of knowledge from professionals to patients

Professionals' control over the quantity and quality of knowledge passed to patients has been examined by Sinivaara, *et al.* (2004). Their study analyzed data collected through a questionnaire administered to 155 midwives and nurses caring for women during delivery in Finland. Nurses reported that they commonly withheld information, gave information in a hurry and made decisions on patients' behalf. Sinivaara and colleagues argued that nurses' control over passing information to patients is a practice of power as it limits patients' access to information regarding their cases, and has an impact on their ability to participate and make independent decisions regarding the care presented to them.

Although the existence of a hierarchical patient-professional relationship is obvious from the empirical literature, recent research and policy (Department of Health, 2009: 6) displays an increasing desire for a move towards a more patient centred approach and increased patient involvement in the clinical process: what has been described as a move to give patients "more power over their own health and care". Jayadevappa & Chhatre (2011) argue that patients should be empowered to make autonomous decisions about their treatment. However, it has been noted elsewhere that patients often ask professionals to make decisions on their behalf because of their own lack of knowledge (Avis, 1994), and it is therefore argued that patient-centred care can only be achieved if patients are given more information about their condition, and the "free flow and accessibility of

valued information” between patients and professionals is ensured (Jayadevappa & Chhatre, 2011: 16).

2.3 Publicizing of subjective needs and complaints

Another way in which professionals exercise power in the clinical setting is by normalizing patients’ subjective needs and complaints. Johnson & Webb (1995) argued that making patients’ private needs, such as defecation, public is an exercise of power over patients who might have no choice in refusing such intervention. Normalizing such private requirements in a clinical setting and dealing with them in the same fashion as practices such as eating and sleeping may decrease the patient’s willingness to reveal such needs.

Similarly, it is argued that a reluctance to report pain might be associated with the position of the patient in relation to their nurses. In some cultures where masculinity and pride are dominant, patients, especially males, may feel it necessary to appear stoic, and under-report their pain. Patients may also be reluctant to report pain if they do not want it to be publicized in front of other patients, visitors, or female nurses (Chapter One, Section two, Subsection 4.1).

2.4 Effect of the social hierarchies on patients’ pain practices

Professionals may also exercise power non-verbally and perhaps unintentionally through the way in which patients view them, and patient reluctance to report pain might therefore be affected by the social standing of doctors and nurses. In Jordan, for example, it has been observed that patients “have absolute trust in the physician” (Haddad, Kane, Rajacich,

Cameron, & Al-Ma'aitah, 2004: 88), and “regard their physicians as authority figures, and therefore, they may be eager to... be good patients” (Al-Hassan, Alkhalil, & Al Ma'aitah, 1999: 387). Thus, it is argued that the high status of health care professionals may encourage patients to regard complaining about their pain as incompatible with, and ultimately less desirable than, being considered a ‘good patient’.

Finally, the hospital in which professionals work can reinforce their dominance in dealings with patients. As has been noted:

“It can be said that ... the hospital is the home terrain of the staff, especially of the physicians and nurses, and they make and enforce the basic rules which prevail on their wards and around the bedside,” (Fagerhaugh & Strauss, 1977: 8-9). It may therefore be argued that any discussion of the effect of professional status on patient practice must also consider the unique situation of the hospital, and the relationships such an environment encourages.

3. Organization

It has been observed that “Discourses do not exist in simple bipolar relations of power and powerlessness” (Weedon, 1987: 110), rather that they are “tactical elements or blocks operating in the field of force relations,” (Foucault, 1998: 101). This implies that any attempt to understand the distribution of power in nurse-doctor relations, or professional-patient relations, must be considered within the field where these interactions take place, such as their organizational context. That is because the manner in which discourses constitute our understanding of reality is, as Weedon

argues, “always part of the wider network of power relations, often with institutional bases,” (Weedon, 1987: 108).

An obvious gap in the clinical research is the lack of consideration of the influence the hospital as an organization can have on pain management, and on people’s practices and interactions generally.

It has been argued that any attempt to fully understand the influence of an organization requires a shift from considering it as a static and objective structure, to an appreciation of its role as a dynamic set of different discourses that have the potential to influence an individual’s actions (Brown & Humphreys, 2006; Faith, 1994). In other words, discourses are, as Fairhurst & Putnam (2004) argued, foundational to any attempt to understand the dynamic nature of an organization because organizations are embedded in and embody discourses. It has been further suggested that an organization can be considered a field of power relations between competing discourses which operates to construct a social reality, and therefore influence people’s practices and perceptions (Brown & Humphreys, 2006). By legitimating its own knowledge and practices, and marginalizing those of others an organization can therefore serve to influence and restrict the actions of those individuals engaged within it (Foucault, 1980). Thus, it becomes reasonable to argue that the hospital may play a role in constructing and politicizing individuals’ subjectivity, and consequently their actions. It has been speculated by Foucault (1977) that organizations construct or modify individuals’ practices through a number of disciplinary power mechanisms that include *normalization*, *hierarchical*

observation, and examination. These will be examined in the specific context of hospitals below.

3.1 Normalization

Normalization is a mechanism that “refers individual actions to a whole that is at once a field of comparison, a space of differentiation and the principle of a rule to be followed” (Foucault, 1977: 182). When new norms in clinical interactions and practices are created, people are expected to follow them (Carr, 2009). Normalization might be embodied in the organizational policies and philosophy of an organization, which, as Henneman (1995: 360) stated, determine how individuals ‘function’.

The collective culture of hospitals or departments also constitutes normalization by establishing, reinforcing and applying certain norms. Harper *et al.* (2007) and Harper (2006) investigated the influence of military organizational culture and collective norms on pain management. They found that those involved in healthcare within a military context often behave in a controlled and structured manner and expect their patients to behave in a ‘predetermined way’ (Harper *et al.*, 2007: 602).

Harper (2006) observed that members of the military are trained to tolerate stressful conditions and this is often reflected in an expectation that others should endure suffering without complaint. Harper *et al.* (2007) reported that many military nurses assess patients’ pain regularly but that their conclusions often rely on the common sense knowledge that has developed during their time working in the military service. Harper *et al.* (2007)

reported that military nurses ignored patients' self-reports of pain where they felt patients to be exaggerating their experience.

Wild and Mitchell (2000) reported that attitudes to pain are shared within a nursing unit, shaping collective thinking about pain and pain management. By defining what is normal and what is not, the collective culture could also shape collective practice. More recently, Clabo (2008) used Bourdieu's theory of practice to examine such contexts, and found that nurses' pain assessment practices are profoundly shaped by the social context of the unit where practices take place.

Thus it can be argued that the effects of normalization, whether induced by higher organizational policies and personnel, or derived from a collective departmental culture, play a significant role in constructing and modifying the attitudes and practices of those professionals involved in pain management.

3.2 Hierarchical observation

This is the second mechanism through which an organization may exert its disciplinary power on individuals. Hierarchical observation "is the process by which those at the *top* view all others below them. This process affects nursing from within its own discipline as well as from outside of it," (Henneman, 1995: 362). Hierarchical observations may be carried out by nurses themselves, for example through inspection rounds of nursing administrators, or by others such as doctors who, through the power and

authority granted to them by organizations and society, acquire the right to observe and judge nurses' work.

Rejeh *et al.* (2009; 2008) reported that the lesser authority given to nurses in the area of pain management, especially in relation to the more significant role played by physicians, operates as a hindrance to the effective management of postoperative pain in Iran. This might be, arguably, because the hierarchical and unequal power structure of the nurse-doctor relationship impedes the ability of nurses to apply their knowledge of patients and participate fully in decision making. Hierarchical observations might also be exercised by those who are at the bottom of the hierarchical system of relations (Foucault, 1977: 177). Patients, for example, through *gaze* might exercise power over professionals, in such a manner as to make their job more vulnerable and less private (see Chapter six, Subsection 1 of this study).

Hierarchical observation, according to Foucault, is a type of surveillance that exerts power through a process made manifest in the 'Panopticon'. In the Panopticon, individuals are placed in separate rooms under the continual observation of an anonymous guard, in a construction in which it is possible for one guard to observe many individuals at same time, but impossible for the individuals to see the guard, or tell whether they are being observed (Foucault, 1980, 1975). Foucault used the Panopticon as a metaphor to explain how individuals subjected to continuous surveillance and gaze begin to develop certain actions of self-surveillance. It is argued that it is not only hierarchical observations that can operate in this way, but

that such power extends to other situations where nurses and patients feel themselves under continuous inspection by others in their surrounding [as this study argues; Chapter Seven, Subsections [II: 2.1] & [IV: 1.1]).

3.3 Examination

This is the third mechanism by which an organization might influence the practices and attitudes of individuals. *Examination* merges the power of hierarchical observation and normalizing judgement. As Foucault explains, “it is a normalizing gaze, a surveillance that makes it possible to qualify, to classify” (1977: 184), and to judge. In hospitals, nurses and doctors exercise examination over patients when they establish their history. Holmes *et al.* (2006: 3) argue that taking a patient’s information, and turning it into a case enables professionals to judge a patient as ‘normal’, ‘deviant’, ‘demanding’, or otherwise classify them according to other set characteristics. Thus, the asymmetrical professional-patient relationship is reinforced and the patient is further weakened and placed at a greater risk of marginalization.

As has been observed however, “organizations and their work cannot be understood without relating them to the larger context of the social world in which they are embedded” (Fagerhaugh & Strauss, 1977: vi). An organization should not be considered separate from its social context, but rather, grounded in the social discourses (Fairhurst & Putnam, 2004).

Social institutions, including organizations, such as hospitals, should be regarded as fields of power relations that, as Weedon (1987: 110) wrote, “take specific forms in particular societies, organized, for example through

relations of class, race, gender, religion and age”. By discussing the effects of society it may be possible to further develop a greater understanding of the factors which influence people’s practices and interactions.

4. Society

Society can be viewed as a complex set of discourses and relations of power which influence individuals. Societal discourses, for example gender and religion, might influence how both health professionals and patients perceive pain and the pain management practices. The following research identifies two social processes which contribute to the construction of social discursive practices among people involved in pain management: the process of gender socialization, which reproduces beliefs, values and expectations associated with gendered identity; and effect of the mass media, which may operate to produce ‘hyper-reality’ regarding pain and professionals.

4.1 Gender socialization and stoical beliefs

The socialization process provides both males and females “the discursive practices through which to locate themselves as individuals and as members of the social world” (Davies, 1989: 299). The socialization process transfers expectations of how different genders should behave through family life, educational process, and the media (Cummings, 1995).

In addition, the socialization process transfers the boundaries of relationships between genders, and accordingly can influence people’s interactions and practices. This can extend into workplaces depending on the potency of gender discourses in any given society (Campbell-heider &

Pollock, 1987). In societies where gender issues impose strongly on relations between individuals, professionals' practices might be influenced by the system of social norms and expectations, and this may have an effect on the relationships they establish.

In addition, the socialization process operates to construct people's conceptions and beliefs. For example, stoical attitudes to episodes of pain among both genders might be attributed to the socialization process of females and males in different societies. Bendelow (1993) reported men's reluctance to express pain, and explained this in relation to perceived social expectations and childhood socialization. In Jordanian culture, stoicism is admired in men under stress (Shoup, 2007), and thus, males might under report or even hide their pain. Johansson *et al*, (1999) examined female descriptions of symptoms and suggested that expressions of pain among women may be associated with their subordinate status and gender. McDonald *et al*, (2000) reported that patients did not communicate their pain when asked about it by healthcare providers because they considered such questions "social interactions and responded as they did because societal norms require politeness and absence of complaints" (p:74).

Stoical beliefs might also be reinforced by different religious attitudes. For example, in the past, Christians sometimes refused analgesia during painful events such as childbirth as they thought such an occasion to be "a necessarily painful process" (Brennan *et al.*, 2007: 207). Similarly, some Jordanian Muslim patients still believe that enduring pain purifies sins and that pain is a test of faith (Abushaikh, 2007). Many Muslims might

therefore delay seeking pain relief, preferring to use prayer to help them to cope (Al-Hassan & Omran, 2005).

Whatever the explanation of patients' reluctance to report pain, such aversion is significant in the pain management process because it leaves patients experiencing pain silently. As mentioned previously, this has a serious impact on patients' pain levels, especially if the painkiller is prescribed on a PRN regime (Winefield *et al.*, 1990).

4.2 Mass media

Social beliefs regarding pain and, even regarding professionals and their roles in pain management, may be at least partially influenced by the mass media. There is, however, an absence of research examining and explaining the role of media in shaping public beliefs and attitudes to pain management.

Mass media might influence pain management through the messages conveyed in films, health promotion serials, and TV programmes about opioids and the way health professionals are depicted. The influence of the media on clinical processes may produce intentional or unintentional realities. Baudrillard (1983: 146) termed this 'hyperreal', and this study will argue that this concept of 'hyperreal[ity]' could be engaged to explain many people's concerns regarding pain management, such as addiction to opioids, and the way images of professionals might influence patients' interactions or expectations of professional practice. Negative images of nursing in the media operate to "... distort the public's concept of nursing and reinforce an

outmoded legacy of beliefs, expectations, and myths about nursing... Consumers [e.g. patients], too, are affected as these portrayals deprive the public of knowledge of the many vital services that nurses provide” (Kalisch & Kalisch, 1983: 48).

Concerns regarding the image of professionals in the media stem from the potential influence such presentations may have on patients’ preferences and their reporting of pain. In an empirical study, Sills *et al.* (2009) found that patients reported pain to doctors and nurses differently, but provided no explanation for this finding. It could be suggested that the origin of this may lie in the different depictions of doctors and nurses in the media, as Kalisch & Kalisch (1986: 179) stated, “when compared with media physicians, media nurses were consistently found to be less central to the plot, less intelligent, rational, and individualistic, less likely to value scholarliness and achievement and exercise clinical judgement... than physician characters”.

Subject: Body and consciousness

The previous section established that different factors can be seen to influence the ways people behave, and Foucault’s insights into power were used to explain some of these behaviours and practices. The work of Foucault has particular relevance here as his ideas were mainly built on analyzing and studying the “question of body and the effects of power on it” (Foucault, 1980: 58).

However, the human, as sociologists such as Bendelow and Williams (1995) have stated, is composed of body and mind, and thus consciousness, and it is thus to be expected, as Neo-Marxists have argued, that there are factors

which might influence human behaviours by exerting power on the level of consciousness.

In his work, Foucault was attempting to move away from the debate about consciousness, and his writings contain little discussion on this subject. Thus, Foucault was not discussed frequently in relation to ideas regarding consciousness, which, thus, might limit his insights of the influences of power on people's behaviours in this study. Because of this, it was essential for me to turn to other philosophers who studied the influence of power on consciousness.

The power system, in Gramsci's theory for example differs from that of Foucault. In Gramsci's system of power, termed *hegemony* (Gramsci, 2011, 2000), domination exerts effect on the level of consciousness through ideology. The difference between the two power systems, 'interiorization' and 'hegemony', is the final result. In Foucault's system the power of 'interiorization' operates on the level of the body, and results in docility or resistance, or both of these combined. The power of domination or 'hegemony' provokes docility or unquestioned subordination to hegemonic forces, but no resistance.

"Hegemony... is power by consent or the domination of the ruling class to persuade other classes that their interests represent the good of all. The interests of the ruling classes are thus presented as the common interest and taken for granted as such" (Gjerde, 2004: 145).

A post-structural reading of Gramsci's theory makes it possible to apply these ideas even to tribal-based communities where cultural ideas and norms are set by dominant groups of people, such as males in patriarchal societies.

Thus, in this study it would be more useful to understand hegemony as a result of, as Crehan (2002) argued, a mutual relation between the power and culture or cultural discourse and the effect of this relation on people.

But how might the power of culture affect people's actions?

Hall, Neitz, and Battani (2003) argued that "culture is a medium of power; people who operate within the boundaries of a culture are dominated by its categories and meanings" (p: 174). Thus, people who 'deviate' or fail to meet cultural expectations might face culturally set penalties or 'sanctions'. Deviating or escaping from societal expectations, or the taken-for-granted cultural certainties, is difficult and, it is argued, not feasible on an individual level. It is suggested that this is why culture remains dominant over its individuals, and is why many people conform without resistance to their culture.

It is important in this context to understand culture as more than a set of norms and traditions. It is 'dynamic, fluid', provoking 'discursive' practices that are also limited by its 'hegemonic forces,' (Gjerde, 2004: 153).

This thesis will draw on Foucault's insights of power, knowledge and body to explain the findings that emerged from data collected in two Jordanian hospitals regarding factors influencing pain management. However, remaining consistent with the adapted post-structuralist position, analysis will also involve consideration of other theories, such as those of Gramsci, to help understand phenomena that Foucault's ideas could not explain.

In summary, this study could have utilized a framework regarding the development of nursing as a profession but it was felt that this would not have fully captured the complexities of pain management. However, the post-structural perspective used in this study will help analysis and interpretation of emerging issues from different aspects. The post-structural perspective is used because instead of blaming one or more of the parties for their practices as factors impacting on pain management, it allows for the possibility of exploring how and why these practices were constructed in the way that it is described, mainly in the clinical literature. In other words, post-structuralism is used to explore assumptions and understandings underpinning the practices that are taken for granted to influence pain management in clinical settings (Cheek, 2000). Finally, it is anticipated that a post-structuralist perspective will help explain what other views and perspectives were excluded when factors influencing pain management were presented in the literature, and why they were excluded (Cheek, 2000). That is because “post-structuralism recognizes the presence of multiple voices, multiple views, and multiple methods when analyzing any aspect of reality. Who and what is absent is thus of as much interest as who or what is present” (Cheek, 2000: 5).

There is further discussion of such a post-structuralist position in Chapter Three.

Concluding remarks

Whereas the reviewed clinical research focused on the practices and knowledge of patients and nurses merely as factors that influence

postoperative pain management, the examined social studies sought the origins of such practices, and suggest they are politically constructed under the influence of multiple discourses and contexts. Thus, clinical practices “should not be our focus of attention in themselves as pure ethnographic descriptions. Rather, they are a starting point for unveiling what lies behind” (Davies, 2003: 721).

It is intended that this research will study the factors which influence pain management from a post-structuralist perspective, to ‘unveil what lies behind’ taking into account that one paradigm alone cannot present the issue comprehensively.

Viewing organizations and society from the position of post-structuralism is an essential character of this thesis, and it is expected that such an approach will to help to reveal some of the key factors that influence both patients’ and professionals’ practices and interactions, which in turn shape the pain management process.

The next chapter will explain some of the social issues in Jordanian society, in particular those related to culturally set boundaries of gender relations. It will also present an overview of the country’s health system to allow for a more complete understanding of the clinical settings in which the research was conducted.

Jordan: An overview of the research setting

Introduction

The purpose of this chapter is to introduce the reader to the context of this research, and to enable an understanding of the events within their natural settings.

In addition to a brief overview of Jordanian geographic and demographic characteristics, a sketch of historical and socio-cultural issues is provided. It is argued that these contexts contribute to the construction of the practices and interactions described in the findings of this thesis. Finally, a summary is provided of the organizational system of health services in the country.

1. Geographical overview

Jordan is a country of 89,342 km² (Jordan Ministry of Health (JMoH), 2005), which lies in the Middle East and has terrestrial borders with Iraq, Syria, The West Bank, Israel, and Saudi Arabia (Figure 1). The short distance of only 70 miles between the capital, Amman, and the Mediterranean Sea beaches, means Jordan is considered a Mediterranean country even though it has no borders on the sea (Shoup, 2007).

Figure (1): Map of Jordan and nearby countries



The North and Middle West regions of Jordan include the majority of the big cities, from Irbid in the far North to Karak in the Middle of the country. South of Karak, and particularly near Aqaba in the far South, desert-like lands become more prevalent and the rainfall rate decreases.

2. Demographic characteristics

The Jordanian population was approximately 5,980,000 in 2009, according to the official records of the Jordan Department of Statistics (JDoS, 2010). In 2010 the rate of population growth was 2.2%, and the population density 67.4 persons/km² (JDoS, 2010), this compares to 60 persons/km² in 2004 and 47 persons/km² in 1994 (JMoH, 2005).

Life expectancy is currently 74.4 years for women and 71.6 years for men (JDoS, 2010). The most common cause of death among Jordanians is Ischemic heart diseases followed by road traffic accidents (WHO, 2006), with 20.5 accident/1000 population (JDoS, 2010).

Jordan has a high fertility rate at around 3.8 children/woman in 2009 (JDoS, 2010), although this has decreased from 7.0 children/woman in 1976 (JMoH, 2005). The high fertility rate translates to 37.3% of the population being under 15 years of age, 59.5% between 15-64 years, and 3.2% 65 years of age or more (JDoS, 2010).

The official religion in Jordan is Islam, with 80% of Jordanians being Muslim Sunni (Shoup, 2007), and a relatively small number of Shi'ites. About 20% of Jordanians are Christians, the majority of whom belong to the Eastern Orthodox Church (Shoup, 2007). The followers of both religions enjoy similar social status, rights and duties (George, 2005), and “culturally, there is very little to differentiate one from the other” (Shoup, 2007: 42). Jordan also includes some Druze who moved to Jordan from Syria and Lebanon in 1925 (Shoup, 2007), and minorities of Circassians and Chechens (Non-Arab Muslims) who left their homes because of Russian persecution in the Caucasus in the 1880s (George, 2005).

3. A brief historical overview

Jordan is a land of many old civilizations. The oldest known culture developed in Jordan, Natufian culture, is about 13,000 years old (Shoup, 2007: xi).

Before being under the Islamic governance, Jordan was considered one of the Byzantine territories (Shoup, 2007). In the early Fourth Century A.D., some Bedouin tribes started to move to the area, and supported Byzantine forces in their wars with Persians who were mostly based in present-day Iraq and Iran.

Early in the Seventh Century A.D., Jordan came under the Islamic governance of *Khalifah (the Muslim ruler)* Omar Ibn Al-Khattab, and this encouraged the immigration of some Bedouin tribes from Saudi Arabia to Jordan (Salibi, 2006).

The modern Jordan state is relatively new. Before it was made officially independent from the British mandate in 1946 at the time of King Abdullah I (George, 2005; Robins, 2004), it was controlled by the Ottoman Turks, as were many other Arab countries, between 1517 and 1918 (Shoup, 2007).

The historical development of the state of Jordan has influenced the Jordanian social system and its customs and traditions, and reinforced some customs through its various policies, including those that have “served to maintain various forms of patriarchal control” in the society (Brand, 1998: 100).

4. Language in Jordan

Jordanians, regardless of ethnicity or religion, speak Arabic, which is the official language of Jordan (Shoup, 2007; Library of Congress Country Studies, 1989). Throughout the Arab world Arabic language exists in two forms: classical Arabic, which is referred to as *Fusha* (clear speech) (Shoup, 2007: 45), and the local form of the spoken language or dialect, which differs from country to country in the Arab world (Library of Congress Country Studies, 1989). However, there is a wide consensus among Arabic speakers that the classical form “is superior to the spoken form because it is

closer to the perfection of the Quranic language” (Library of Congress Country Studies, 1989).

Classical Arabic is used officially, whether in royal speeches, in governmental and official decrees, or official media and press. The majority of Jordanians understand and can speak classical Arabic, however in their daily life they use the local dialect. Some terms created and used by people have no roots in the classical Arabic language, and thus, translation into English may be difficult and can result in some loss of meaning.

In higher education, the majority of undergraduate majors and higher education specialities are taught in English, with some exceptions such as Shari’a (Islamic Law), Arabic literature and Law. Other scientific, natural, and health majors and specialities, such as, but not limited to, physics, chemistry, nursing, medicine and engineering, are taught in English.

In nursing, all of the taught textbooks are Western, mostly American. All exams and the majority of discussion between clinical instructors and students in lectures and clinical settings are held in the English language.

5. Social structure-related issues and customs

Topics covered under the following subsections influenced both the participants’ and the researcher’s practices and attitudes during fieldwork. It seems therefore important to offer some clarification of how they operate within the wider context of Jordan.

The tribes that inhabited Jordan in the early Islamic age of the Seventh Century A.D., and later with the coming of King Abdullah I from Saudi Arabia in 1921 developed a community from which the majority of the current indigenous Jordanians derive (excluding Jordanians of Palestinian origins). However, the real Bedouin, or, “those who raise livestock as their major source of income” compose only 7% to 10% of all Jordanians (Shoup, 2007: 5). Nonetheless, it is clear that the whole Jordanian community has been affected by aspects of Bedouin culture, or in other words, has been ‘bedouinized’ in many respects, including speech, mannerisms, customs, and behaviours (Shoup, 2007: 7).

Accordingly, Jordan can be described as a tribal state. This means that to a large extent, Jordan’s political organization and individuals’ personal identities are based on the concept of the tribe. The tribe is here understood as “a social division in a traditional society consisting of families ... linked by social, economic, religious, or blood ties, with a common culture and dialect” (Oxford Dictionaries, 2010d). The family, in its turn, is the basic unit of the Jordanian tribal society and one of its ‘major strengths’ (Shoup, 2007: 87). When discussing the Jordanian family, characteristics of patriarchy, conservativeness, and honour will be highlighted.

5.1 Patriarchal family structure

Similarly to most other Arab family structures, the Jordanian family is patriarchal. The male is the head of household, the main decision maker, and the person who holds a disciplinary role. “Males held socially superior status, even over elder sisters, and a much younger brother could forbid his

elder sister from leaving the house or require that he as the male accompany her,” (Shoup, 2007: 88). This patriarchy, which is constructed culturally, controls female life in Jordan despite the presence of certain legislation that aims to liberate women (Miller, 2009).

The tribal make up of Jordanian society has strongly reinforced its patriarchal character, and has also played a strong role in shaping the country’s laws, as much as it “molds (*sic*) the character of its people and the relations among them” (El Azhary Sonbol, 2003: 7).

5.2 Conservatism

The tribal and Bedouin make up of Jordanian society has formed its conservative characteristic, whether in its Muslim majority or Christian minority. Such conservativeness is reflected in common ideas within Jordan about “appropriate dress, behaviour, and gender relations” (Shoup, 2007: 87).

Jordanian society practices gender segregation in some respects. Gender segregation and the desire to maintain a social distance between the sexes has influenced the way Jordanians construct space. For example, the majority of Jordanian houses and apartments are built with two entrances, one providing access for family members, the other opening into a special room reserved to receive guests. In this way, guests do not need to pass through parts of the house where the family lives. On many occasions, and depending on how close the guests are to the family, male guests may not see any of the females living in the house (Shoup, 2007: 39-40).

The purpose of such space identification is to prevent any unacceptable mixing between the sexes. This space identification is also applied in hospitals where female wards do not accommodate any male patients or male nurses. This links to the notion of the socialization process controlling how sexes mix: it is the idea of 'honour' (*sharaf* or *ird*).

5.3 Honour

Honour is an essential principle in Jordanian society and has the same important role for Muslims and Christians. Honour is influenced and directly connected with individuals' behaviour and is collective: unacceptable behaviour by one person can ruin the honour of their whole family. In other words, "the entire family is judged by the actions of an individual, as the actions of individuals reflect the general moral level of the whole family," (Shoup, 2007: 40).

Although honour is connected with the practices of all the individuals within a family, it is more closely linked with the behaviours of females as opposed to males, as females carry the greatest responsibility of their families' reputation (Shoup, 2007: 89). This may explain why in honour crimes, the victims are almost always woman suspected of sexual misconduct (Miller, 2009; George, 2005).

Honour crimes, or as they are usually called in Jordan, '*Jarimat al-sharaf*' (Brand, 1998: 104), are carried out upon behaviours which cause serious offence to family honour. Such behaviour causes shame, and a family's honour is 'blackened', and therefore necessitates a 'whitening', redress, or

restoration if the family is to regain its respectability in the community, (George, 2005; El Azhary Sonbol, 2003; Brand, 1998). “Patriarchal law and societal normalization of these traditions... have dictated that the only accepted technique for restoring such honor (sic) is by way of physical abuse, frequently involving the bloodshed and murder of the ‘culpable’ female (and only the female) involved” (Miller, 2009: 10).

Mostly, honour crimes are carried out by male relatives, regardless of their age, against females who were suspected of misconduct. In Jordan, “about 25 women fall victim to honour crimes each year, accounting for a large proportion of all murders in the kingdom” (George, 2005: 199).

Honour is often associated today with Islam, but it is not uniquely so. Although Jordan is an Islamic country, understanding the status of men and women requires consideration of the interaction of a complex set of factors, of which Islam is only one (Brand, 1998). “Over time, any religion is interwoven with or conditioned by structures and traditions of the society into which it is introduced” (Brand, 1998: 105). *Urf* (traditional tribal or village law) plays a key role in Jordanian society, as well as *Shari’a* (Islamic law). However, “the state’s reliance on the tribes, and its cultivation of them through provision of various types of patronage, has strongly increased the importance of tribal values and norms in Jordanian society, whether they are actually codified in law or not,” (Brand, 1998: 105). Because the priority in tribal law is to maintain the honour of the family, Jordanian codes of law grant primacy to the principles of honour, providing some indirect legitimacy to the right of a brother, father, or

husband to kill a female relative he ‘suspects’ has been involved in illicit sexual contact (Haddad & Esposito, 1998). The result of honour crimes is often a light prison sentence for the killer (Brand, 1998), which might be only as short as six months. So, the *Urf*’s effect in Jordanian law is greater than that of the Islamic law. Thus, although often portrayed as an Islamic phenomenon, honour crime is in reality more a matter of tradition. Nothing in Islam, neither in the Sunnah (Prophet heritage), nor in Qur’an, provides for such brutality (George, 2005; El Azhary Sonbol, 2003; Brand, 1998).

When discussing honour crimes and the extent of the effect of social traditions and customs on Jordanians, it is important to understand how females, particularly those working or treated in hospitals, behave, practice, and interact with individuals of the opposite gender. Of particular importance for this study is the influence of these traditions on specific health issues, including how they express their pain in the presence of strangers, whether professionals or visitors (Chapter six, Section One, Subsection 3). The controlling outlook upon women is centrally concerned with morality, which is almost exclusively focused on sexuality, through the term honour (El Azhary Sonbol, 2003: 220). As such, protecting females, especially those working side by side with males is considered a moral societal norm, and women are expected to control their own reputations.

5.4 Respect

In Jordan, children are taught from early childhood to respect their parents and older members of their family. This respect can be expressed by speaking politely to strangers, by referring to older people by ‘uncle’ or

‘aunt’ (Shoup, 2007: 101), or even by kissing the hand of their father or mother. The researcher used ‘uncle’ and ‘aunt’, ‘mother’ and ‘father’ when talking to older patients to show them respect and to establish a kind of rapport built on polite behaviour (Chapter Three, Subsection 4.10.1:D).

5.5 Social visiting and hospitality

As was mentioned previously, Jordan is a strongly ‘family-oriented society’, and among the social customs maintained to this day is that of visiting family and friends. (Shoup, 2007: 101). Visiting family and friends is an important custom that aims to maintain the family ties and to demonstrate friendship.

A number of norms and traditions are connected with visiting. For example, “food and drink are important features of visiting, even between close friends and family members. For a host not to provide at least fruit, sweets, coffee or tea would be the mark of both bad manners and a poor host” (Shoup, 2007: 102), even if the host is ill, or hospitalized. That is why patients still kept some Arabic coffee or sweets and chocolates at their bedsides.

Refusing or accepting coffee or what the host offers a guest is an issue of importance in visitation customs. As Shoup explains, “to visit and refuse to eat, or to take a coffee or tea would mark a cold relationship and even hostility on the part of the guest” (2007: 102).

5.6 Use of personal influence (*Wasta*)

The use of personal influence (*wasta*) is a type of collective social behaviour including nepotism, favouritism, and cronyism (Box 1). In general speech, the use of personal influence (*wasta*) indicates that the individual, or group of people, receives preferential treatment over others, whether they are patients, nurses, doctors or others. In the literature, The use of personal influence (*wasta*) means the use of social networks, usually family or tribe, to secure benefits that would not otherwise be gained (Hutchings & Weir, 2006; Cunningham & Sarayrah, 1994).

Box 1: Definition of practices related to the use of personal influence (*wasta*)

Cronyism: “The appointment of friends and associates to positions of authority, without proper regard to their qualifications” (Oxford Dictionaries, 2010a)[Online]

Favouritism: “The practice of giving unfair preferential treatment to one person or group at the expense of another”. (Oxford Dictionaries, 2010b)[Online]

Nepotism: “The practice among those with power or influence of favouring relatives or friends, especially by giving them jobs”. (Oxford Dictionaries, 2010c)[Online]

The use of personal influence (*wasta*), similarly to honour crimes, has been reinforced by the tribal and family system in Jordan (George, 2005), and, although legally prohibited in all forms, is practised at both high and lower levels of society. King Abdullah II has called frequently for the elimination of “all forms of administrative bloating, negligence, corruption, abuse of public posts, nepotism, cronyism, and whimsical decisions’ as a means of creating a society of equal opportunities” (George, 2005: 69). However,

Jordanians still rely on their personal or family networks to ‘secure their objectives’ (George, 2005: 69-70), and almost, everyone in Jordan relies on personal influence (*wasta*) in many aspects of life (Hutchings & Weir, 2006; Cunningham & Sarayrah, 1994).

Legislation has had little impact on the use of personal influence (*wasta*) as it is a matter of entrenched social norms. The practices are so embedded in Jordanian culture that fighting them can appear like fighting culture itself. As the former deputy PM for economic affairs, Muhammad Al-Haliqa, said, “For all the official determination to eliminate *wasta* and corruption, the task will not be easy...Our legislations, our procedures, are in that direction. But it’s going to be a lengthy struggle because one has to fight the culture” (George, 2005: 71).

6. Overview of main health sectors in Jordan

In Jordan, three main health sector bodies present services to people (JMoH, 2011b):

- 6.1 The Governmental (public) sector, managed by the Ministry of Health, Jordan (JMoH).
- 6.2 Royal Medical Services, which are managed by Higher Military Command.
- 6.3 The private sector, in which each hospital is managed by its executive administration council.

Health services are also provided to patients of specific classes by two other sectors that supplement the work of other health organizations. These are the University hospitals, and the non-governmental and international sector,

such as United Nations Relief and Works Agency (UNRWA), which mainly presents services to Palestinian refugees.

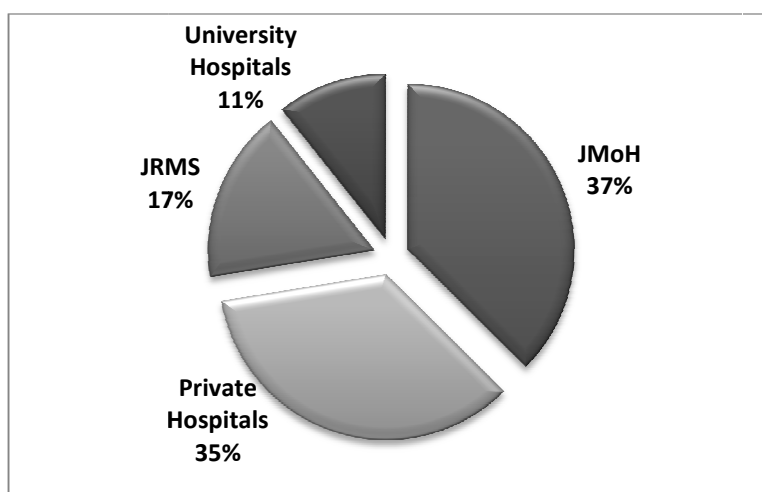
6.1 The Governmental (public) health sector

The Ministry of Health in Jordan offers primary, secondary and tertiary health services to all Jordanians through a large net of comprehensive medical health centres and hospitals distributed throughout the kingdom. Public hospitals are funded through taxation, and provide health services freely or for low fees (Al-Makhamreh, 2005). Those who are not covered by governmental health insurance, for examples those working in the military or in the private sector or those who are not covered by any type of health insurance, pay for health services, or if they have no means to do so provide reports on their financial status provided by the Ministry of Social Affairs (Al-Makhamreh, 2005). It is worth mentioning that about 1.2 million citizens in Jordan are not covered by any type of health insurance (Alghad Newspaper, 2011)

Primary health services are provided by 665 medical health centres distributed across the different regions of the country according to the population density. Dental care is also provided by 262 dentistry medical centres (JMoH, 2005).

Secondary and tertiary health care services are provided through 30 hospitals (total beds = 4250) (JMoH, 2011b). The JMoH beds constitute about 37.4% of the total hospital beds in the country (Figure 2). The JMoH hospitals reported undertaking 86,300 surgeries in 2009 (JDoS, 2010).

Figure (2): Percentage of beds each health sector make up of the total number of hospital beds in Jordan



6.2 Jordanian Royal Medical Services (JRMS)

This health sector provides health services to individuals who work in the security and armed forces, to their dependants, retired members of the military, diplomatic people, such as ministers, parliamentarians and others. JRMS provides health services to about 30% of the total number of patients in Jordan (Figure 2), via ten hospitals distributed around the country.

6.3 Private health sector

This sector provides health care services to clients through 61 advanced private hospitals. The total number of beds is 3970, constituting 34.97% of the total beds in the country (Figure 2) (JMoH, 2011b). The private sector also includes 5000 private and specialized clinics for specialists and consultants in all branches of medicine (JMoH, 2005).

6.4 Health workforce

The number of working staff members in the Jordanian health sector has increased hugely in recent years. For example the number of nurses has

increased by a factor of nine since 1975, and similar rapid growth in staff numbers has occurred among doctors, pharmacists and dentists.

In Jordan, 22136 nurses worked in health services in 2009 (JMoH, 2011a). Most were native to the country, while 6% came from abroad (Shuriquie, While, & Fitzpatrick, 2008), and mostly worked in private sector hospitals. Figures on the ratio of male to female nurses in Jordan were unavailable. However, some studies conducted in the country, such as that by Al-Ma'aitah and Garaibeh (2000), reported that males constitute about 25% of nurses in Jordan.

In Jordan, the Higher Education of nursing is organized through both the governmental and private sectors, which together provide nursing education through 14 universities (six governmental, and eight private). Since 1998, all registered nurses are required to possess a Bachelors degree as a mandatory requirement for registration (Shuriquie *et al.*, 2008). As mentioned previously, the language of nursing teaching in Jordanian universities and faculties is English, and the majority of taught textbooks are Western. In addition, the majority of educators are Western educated Arab nurses (Shuriquie *et al.*, 2008), who received their training in the USA, UK and Canada, with a few having been trained in other countries, such as Australia and Egypt.

Concluding remarks

Jordan is a tribal and family oriented society. Despite the modernization process that has started to take place recently, the tribal system continues to

control people's customs and norms, especially those relating to gender relations.

Health services in Jordan are provided through three main health sectors. The hospitals studied here were public and military. The reasons for the selection of these sites are introduced in the following chapter, which further introduces the methodology used to collect and analyze data in this thesis.

Methodology and methods

Introduction

Previous chapters reviewed the literature on factors influencing pain management, and suggested that a consideration of contextual factors might be important to an understanding of the practices and interactions of professionals and patients with regard to pain management. The choice of a qualitative case study in two Jordanian hospitals was thus led both by the research questions and the literature review to capture contextual and embedded factors.

This chapter illuminates the philosophy that underpins this study, clarifies the reasons behind selecting the approach of a qualitative case study, and provides a detailed description of how this study was carried out.

1. The post-structural Foucauldian theory underpinning this study

The previous literature review revealed that the majority of clinical research in the field of pain management studied the practices and knowledge of individuals, mainly nurses, doctors, and patients, involved in pain management, without examining the influence of the contexts in which they were operating.

Although numerous aspects of the situation were studied from a number of perspectives, findings have so far failed to bring about any substantial improvement in pain management. This might be because “the realities cannot be understood in isolation from their contexts, nor can they be

fragmented for separate study of the parts. The whole is more than the sum of the parts,” (Lincoln & Guba, 1985: 39).

Because the whole is more than the sum of its parts, this study attempts a post-structural examination of pain management. It looks at those aspects of pain management that are taken into consideration by the clinical research and which make up the main body of empirical literature, while also taking into account the lesser examined areas such as social and contextual factors. Thus, post-structuralism was used to underpin this study because it does not privilege ‘a single authority, method or paradigm’ (Cheek, 2000:4) or discourse.

As Schrift has noted, “post-structuralism is not a monolithic theory with rigid and uniform sets of shared assumptions or axioms” (1995). Rather, it is a perspective that suggests valuing multiple meanings of the same reality (Weedon, 1987), and suggests non-linearity of thinking and acting (Henneman, 1995). Thinking non-linearly was important in this study as a means to shed light on potential factors that had not been captured by structural perspective and quantitative approaches.

The need for a multidisciplinary approach to the study of pain stems from its complexity, and this complexity arises from the interplay between an individual’s unique human biological blueprint and their medical, social, and cultural features. It is therefore argued that no single discourse could adequately approach the issue of pain and pain-management in its entirety (Daibes, 2008). Consequently, achieving optimal management of pain seems to require the adoption of an integrated view of different varieties of

knowledge. This can be attempted, for example, by adopting a biopsychosocial model, as opposed to a consideration of the biological, psychological and social as discrete and separate elements.

This thesis will therefore not presuppose the pre-eminence of medical knowledge. The post-structuralist perspective provides an opportunity to present medical knowledge as one possible 'rhetorical' alternative among many (Agger, 1991: 122). This is not to discount the achievements of medical knowledge in pain management, but rather to ensure that attention is also directed to additional aspects that have received less recognition or have been otherwise marginalized (Cheek and Porter, 1997).

Foucault's insights regarding power, knowledge and subject are used by many post-structuralists to inform both the analysis and explanation of individuals' practices, attitudes, and interactions. There are numerous reasons for my interest in Foucault's ideas. First, his work deals with the clinic and the body under political circumstances, thus relating to my own interest in how bodies are treated when immersed in multiple contextual discourses. Second, it is useful in this study to understand, according to the Foucauldian project of possibilities, that one theory cannot explain everything (Cheek, 2000; Agger, 1991). In any given situation there are multiple positions from which researchers can analyze and explain the same reality (Cheek and Porter, 1997). This typically post-structural theoretical position means that even Foucault's ideas themselves cannot alone explain the totality of emerging themes. In this study it is especially those themes which exert influence on the level of consciousness, such as ideology which

would have been elided with an exclusively Foucauldian framework. This further provides the researcher with an opportunity to look beyond the most commonly used theory, and utilize other, even contradictory ideas, to explain social realities. Therefore, in some parts of this thesis, a post-structuralist reading of Neo-Marxists insights, specifically Gramsci's notes regarding hegemony and ideology (Gramsci, 2011, 2000), is briefly applied to suggest that the concept of consciousness can contribute to the explanation of some practices and attitudes.

It is important to note also that according to a Foucauldian point of view, nothing is independent of its 'genealogy' (Danaher *et al.*, 2000), nor from those variables, past or present, which shape it. Thus, all processes, including clinical processes, practices, and events are to be considered parts of the same social realm. Processes are embedded in, rather than independent of, their contexts (Thwaite, 2004), and are dynamic; adapting to changes of power relations within society and organizations. It is therefore necessary that the realm, i.e. society or organization, where events take place should not be viewed only structurally. The traditional view regarding organizations, first and foremost, as a structure lacks the ability to comprehensively explain individuals' practices and attitudes to pain management. Thus, drawing on Foucault, this thesis views both society and organizations as dynamic apparatuses or processes that exert power through the discourses that shape professionals' practices and attitudes.

The desire to examine contexts as an important influencing factor in the construction of such practices and attitudes informed the selection of a qualitative approach.

2. Choice of qualitative research approach

“Through qualitative research, we can explore a wide array of dimensions of the social world including the... ways that social processes, institutions, discourses and relationships work” (Mason, 2002: 1).

Adopting a qualitative approach helps to connect individuals to their related surroundings, producing contextual-connected findings and conclusions that readers can assess for transferability within similar contexts (Mason, 2002). The connectedness that this qualitative research achieved through a comprehensive view of both the individual and their context enabled the study to develop a more detailed picture of the barriers to change (Pope, van Royen, & Baker, 2002: 148) and answer the question of why improvement does or does not occur in spite of many advances.

The qualitative approach was also selected because it allows for the interpretation of data in terms of an individual’s experiences within their natural daily life, and can therefore help to capture people’s perceptions of phenomena studied, pain and its management, through their experiences (Denzin & Lincoln, 1994: 2). This does not mean however, that individuals’ experiences are wholly and exclusively shaped by their own perceptions and through the meaning they apply to pain management, rather from a post-structural perspective, even experiences are influenced by power relations and strategies that take place in different contexts, leading to

emerging new knowledge (Crowe, 1998). Thus, the precursor to practices and perceptions is the power behind experiences, not necessarily the experiences themselves.

3. Choice of qualitative case study and its design

A multiple case study design, using ethnographic fieldwork as main method, has been chosen as a way to study the issue of pain management within different social and organizational contexts, from a variety of different aspects. The case study, among other methodologies, such as grounded theory, has been selected for the following reasons.

Firstly, it is methodology which allows for an in-depth investigation and holistic understanding of a phenomenon's particularities and complexities as the main intent (Stake, 1995; Feagin, Orum, & Sjoberg, 1991; Merriam, 1988). A case study design aims to combine multivariate conditions to gain a holistic understanding of a certain phenomenon (Yin, 2003a) in its natural setting (Feagin *et al.*, 1991).

Secondly, a case study is an outward looking design (Cohen & Court, 2003), which means that it is open to various contexts within the wider organization and society: "You would use the case study method because you deliberately wanted to cover contextual conditions - believing that they might be highly pertinent to your phenomenon of study" (Yin, 2003b: 13).

Thirdly, a case study applies a 'multi-perspective' analysis. This means that the researcher considers not just the voice and perspective of the participants, but also of the characteristics and interactions of all relevant

groups. This is an aspect of the case study approach of particular significance here, and one which echoes my own post-structuralist perspective. That is, within an organizational setting, the research can seek out data that will “give voice to the powerless and voiceless” (Tellis, 1997: online). Some of the relevant groups such as patients’ relatives were highly marginalized from most pain management research. Yet, it is argued here that they are an important part of the context that influences patients’ and professionals’ practices in pain management.

Finally, the ability of a case study to capture different contexts stems from its capacity to deal with multiple sources of evidence, as no one source of evidence can capture the whole context (Gillham, 2000). That is, a case study may be quantitative or qualitative or both (Yin, 2003b); may utilize quantitative or/and qualitative methods (Feagin *et al.*, 1991: 2); and may be conducted in a comparative framework (Feagin *et al.*, 1991; Ragin, 1987).

Finally, a case study has an ability to capture rich data holistically regarding the cultural context of the studied phenomenon. In addition, it enables a researcher to study the cultural context, while also integrating other considerations such as the organizational, historical and political relations in its analysis. Despite these strengths however, case studies have been criticised for many weaknesses.

3.1 Limitations of case studies

It cannot be ignored that case study methodology has been criticized for its weak reliability (Yin, 2003a), validity, objectivity, and thus, generalizability

(Feagin *et al.*, 1991). However, these characteristics are more likely to be connected to positivist perspectives and research.

- **Reliability** is defined as “the ability to replicate the original study using the same research instrument and to get the same result” (Feagin *et al.*, 1991: 17). In qualitative research however, even if the original study was replicated in the same context, used the same participants, and employed the same data collection methods and analysis, different findings might result because the researcher has an active role in these and has influence through his or her presence in the field (Denzin & Lincoln, 1994). It may be argued that in all naturalistic research, objectivity is inappropriate because the researcher’s system of values, belief, and perceptions all become part of the research process. In fact this makes the qualitative researcher more sensitive to the various contexts and interactions in the field of study (Lincoln & Guba, 1985).

Replication of the qualitative case study might not produce exactly the same findings, as different researchers collect and analyze data from different standpoints. Secondly, participants’ experiences of everyday life influence their views of the issues they examine. Thus, a participant’s view of a certain issue at a certain point in time may differ from their view at another time. Thus, the notion of reliability, as the ability to replicate an original study identically and to receive the exact results, is better understood as a quantitative characteristic that can be used in studies where participants’ and researchers’ influence is a more limited aspect of conducting the study.

However, providing a “thick description” (Geertz, 1973: 16) and a clear account of the procedures that were followed along the entire research journey (Yin, 2003b: 38), including personal interpretations, values, findings, and the setting of the study, help the reader to see how such findings have been produced, and enables them to better understand or repeat the study, and also judge whether the findings can be transferred to other settings (Pope *et al.*, 2002). As such, the thick description or documentation enhances qualitative transferability as a form of generalization.

In addition to close or ‘thick’ documentation of how work progresses, a continuous process of reflection by the researcher is important in ensuring the rigour of collected data since the case study methodology has also been criticized for promoting the “idiosyncratic bias of the investigator” (Feagin *et al.*, 1991: 18), as it is the researcher who constructs interpretations and labels and analyses evidence. Continuous process of reflection includes reflection from the early stages where the study is developed and through to conducting the fieldwork itself. It is also necessary to show the researcher’s methods of processing data and constructing conclusions to enable them to better repeat the study.

- **Validity:** Validity “refers to the issue of whether an indicator (or set of indicators) that is devised to gauge a concept really measures that concept” (Bryman, 2008: 151). Validity in conventional research might be measured in several ways, these are: internal validity, external validity, and construct validity. Internal validity is “establishing a causal relationship, whereby

certain conditions are shown to lead to other conditions, as distinguished from spurious relationships”, and can be achieved by addressing rival explanations (Yin, 2003b: 34).

External validity, on the other hand, is “establishing the domain to which a study’s findings can be generalized”. This can be achieved in research using a single case study design by using a theory, or in the multiple-case study design by using replication logic (Yin, 2003b: 34). That is, rather than depending on statistical logic to enhance external validity, writers such as Yin (2003a: 47) have argued that qualitative case studies depend on replication logic, and results are enhanced by examining multiple cases.

According to Yin (2003b), using multiple case study design can yield both literal replication and theoretical replication. Literal replication means that the selected case produces results that can be found in other similar cases. Theoretical replication means that the case and framework used can produce different results from other cases because of different and expected conditions. For example, in my research, it was proposed before conducting the fieldwork that I select two different contexts, a military situation which is a ‘highly structured environment’ (Kocher & Thomas, 1994: 61) in which nursing care practices follow a rigid care model, and a public hospital in which nursing care practices do not follow a specific care model (Shuriquie *et al.*, 2008). It was felt that such a combination would allow both literal and theoretical replication (Yin, 2003b). Some of the factors were similar in both hospitals among analogous cases (wards of patients of the same gender) as they share the same Jordanian social context. In addition,

different organizational structures were proposed to consider a different range of influences, opening up the design for theoretical replication among hospitals of varying organizational structures. In this research, both types of replication logic have been attempted.

Construct validity is “establishing correct operational measures for the concepts being studied”, and this can be achieved by taking precautions such as using multiple sources of evidence (Yin, 2003b: 34). Stake (1995) and Feagin *et al.* (1991) have argued that case study research has advantages over some other strategies in that it encourages the researcher to collect evidence using more than one data collection method, in what is called ‘method triangulation’. As will be shown in a later section, this research uses multiple data collection methods: non-participant observation supplemented with informal interviews, semi-structured interviews, and document review within multiple cases.

However, it is important to note that the three characteristics discussed previously (objectivity, reliability, validity whether internal or external) do not measure the naturalistic qualitative research trustworthiness (neutrality, consistency, applicability and truth value) (Lincoln & Guba, 1985: 290), because they are more central to quantitative studies. Thus, the following criteria were used to ensure the qualitative rigour of the case study.

3.2 Assuring quality and rigour in carrying out the case studies

It has been mentioned previously that the quality of qualitative research is not assessed in the same way as quantitative research. There are many other

ways to evaluate the quality of qualitative research. Mays and Pope (2006) identify seven criteria through which the quality of qualitative health research can be assessed. These are: triangulation; respondent validation; clear exposition of methods, of data collection and analysis; reflexivity; attention to negative cases; fair dealing; and relevance.

3.2.1 Triangulation

Triangulation is the use of more than one method, source of data, investigators, or theories (Yin, 2003b), in the study of a social phenomenon so that findings may be “cross-checked”, (Bryman, 2008: 700). Triangulation, according to Yin (2003b), is an important test of the validity of a case study. However, for Mays and Pope (2006), it should be seen more as a test of the comprehensiveness of qualitative studies rather than as a mere assessment of validity of a study.

To make the study of factors that influence pain management more comprehensive, multiple data collection methods were used, these were: non-participant observation and informal interviews, semi-structured interviews and document review. Data was also collected from many different sources. That is, multiple perspectives were investigated for similar and different issues, such as patients, nurses, relatives and doctors, in addition to the views of the people in administration positions, such as heads of departments. Collecting data from multiple perspectives served another purpose: “fair dealing”. Fair dealing, according to Mays and Pope (2006), means that rather than relying solely on one perspective, the

researcher takes into account many points of view and is thus more likely to succeed in presenting an issue fully.

3.2.2 Respondents validation

This technique involves comparing a researcher's account with the participants' view in order to see if they have a different view of the collected data or results which emerge (Mays & Pope, 2006). This technique was not applied to this study as it was not feasible for a number of reasons. Firstly, different data was collected from different perspectives and each participant would therefore provide a different account of the findings, and of their individual role in the study (Mays & Pope, 2006). Secondly, re-discussing the collected raw data with participants was difficult because of the inability of the researcher to follow patients, for example, upon their discharge from hospital. Effort was made, however, to reflect upon and summarize each face-to-face interview immediately after finishing it, and attempts were made to verify, with each participant, that the researcher had understood what he/she had meant to say.

3.2.3 Clarity of data collection methods and analysis

This criterion was met by the thick description of all steps carried out to both acquire and analyse the data, enabling the reader to judge for themselves the validity of the data collected and the conclusions drawn.

3.2.4 Attention to negative or disproving data

This criterion means that the inclusion of "deviant cases" or disproving data is important to show alternative explanations, and to avoid biases towards the researcher's perception and theory. My research included contradictory

data and contradictory perspectives and this criterion was met through the reporting of all issues upon which participants disagreed because of their different rank, gender, and authority. On the other hand, this study includes a critique even of the underpinning theory itself in response to its failure to explain some events (Chapter Seven, Subsection [II: 2.2]).

3.2.5 Relevance

Relevant research is that which studies an issue of public concern, and “adds to knowledge or increases the confidence with which existing knowledge is regarded” (Mays and Pope, 2006: 90). Evaluation of the relevance and contribution of this thesis to knowledge is presented in the discussion chapter.

Finally, two other characteristics, reflexivity and positionality, are also used to ensure the rigour of this qualitative case study. These two characteristics are discussed later in this chapter.

4. Carrying out the case study

4.1 Pilot study

For the purpose of examining the interviews’ topic guide, informal piloting was conducted during Easter 2009 in Jordan, five months before starting the fieldwork.

Piloting is “the process whereby you try out the research techniques and methods which you have in mind, see how well they work in practice, and if necessary, modify your plan accordingly” (Blaxter, Hughes, & Tight, 2006: 137). A more generic definition explains that piloting is: conducting a “trial

version of the planned study” (Nieswiadomy, 1993: 32). Many authors recommend piloting, or a preliminary study of the planned research project (Bryman, 2008; Woods & Catanzaro, 1988).

The decision to conduct informal piloting was made for several reasons. Firstly, to gain some experience in conducting interviews; secondly, to identify the effectiveness of topic guides and questions in eliciting data from interviewees; and thirdly to identify if the proposed questions were hard to understand or threatening to interviewees (Bryman, 2008; Johnson & Briggs, 1994).

Appointments with ten pilot interviewees were made two weeks before the interviews took place. Each interview was conducted at a place of the interviewee’s choice. For example, some preferred interviews to take place in their homes, others were interviewed at their work places. These conversations were informal and all of those interviewed were friends of the researcher or people recommended by friends.

Garrett (1965) suggests that the researcher may face difficulties in initiating interviews. I found this was not so with people who were friends, but was true with strangers.

Another challenge I faced during piloting interviews was to keep the older interviewees talking about issues related to the main topic.

Doing the pilot interviews, I realized that writing notes down when the interview was in progress was time consuming and created problems. It diverted my attention from the interviewees’ facial expressions, and made some interviewees think that they should talk slowly for me to write down

their narratives. I was concerned that I could not remember everything pilot interviewees said upon returning home (see Blaxter *et al.*, 2006), and so, a decision was made to use a digital recorder during field interviews.

Piloting the interview guide was useful in correcting some translation mistakes, in noting incomprehensible questions, and in investigating the interviewees' willingness to answer some questions related to, for example, gender, rank, and organizational issues.

The piloting experience also profited me in various ways as a novice researcher. I became more skilful in choosing times to reply or to hold back. It was important to show understanding but not to share ideas about certain topics. In addition, I benefited from this experience by recognizing that I had to think about ways to organize data while being in the field.

4.2 Obtaining ethical approval and access permission

As mentioned above, both the research proposal and the topic guide of interviews were developed taking account of the reviewed literature and pilot study modifications. As expected, ethical committees responsible for each selected site asked to see the research proposal and topic guide of the interviews. The content of the proposal submitted to the committees was carefully considered to avoid use of language that the committee's members would not understand, or were unfamiliar with, especially in respect of the qualitative approach (Guillemin & Gillam, 2004: 263), which is still used minimally in Jordan.

Obtaining ethical and access permission to the sites of the study was obtained in two stages: before and after upgrading from MPhil to PhD.

4.2.1 First stage: Asking for ethical permission prior to upgrading

Requests for ethical permission and access to the sites of study were submitted to four ethical committees, in addition to the University of Warwick as part of upgrading process:

- The Institutional Review Board (IRB) of a governmental university (Appendix Two, A);
- The Research and Human Research Committee of a private university (Appendix Two, B);
- The Committee of Research Ethics in the Jordanian Ministry of Health (JMoH), to gain access to the public hospital (Appendix Two, C).
- The military hospital has no ethical committee. The research project was studied by a panel of expert physicians in the Royal Medical Services (JRMS) command, and was then referred to the intelligence agency and military Bureau to comply with routine checks (Appendix Two, D).

My research project was submitted to these four committees with a cover letter from the Dean of the Nursing school in the sponsoring university, of which I am an employee. The letter clarified my status and the aim of the research.

Access permission from these institutions was granted (Appendix Two A.1-D.1). The Committee of Research Ethics in the JMoH asked for some amendments to the interview guide for nurses and doctors. Amendments were made and re-submitted to the committee (Box 2).

Box 2: Key amendments asked by the Committee of Research Ethics in JMoH

I. Deleted questions

"I have been studying in UK. There, nurses behave differently to here in terms of working with different gender. Would you tell me about what it does look like when a female nurse works in males wards?"

II. Edited questions

Question before being edited

"Do you think there is any thing about the hospital, generally, that influences pain management process?"

Question after being edited

"Do you think there are any organizational factors that might influence pain management process postoperatively?"

The military ethical panel approved the research project without any amendments, and the final agreement was officially obtained when I signed a commitment not to disclose sensitive military information.

The access permission process involved some challenges in the Governmental University. For example, the heads and members of the ethical committee were academic physicians. The head of the committee reviewed my project and refused granting me permission to proceed at the beginning on the grounds that my research design was loose as it was qualitative and did not involve experimentation. He also asked me how interviews, in addition to some observations, would yield measurable findings. Similar comments were expressed by some scholars in the nursing faculty who had read the proposal before referring it to the IRB.

Another challenge presented itself when the head of the IRB in the Governmental University asked me to present in person during the monthly

meeting of the committee to discuss my research proposal. This was not feasible since I was in the United Kingdom at the time of the meeting. I suggested a telephone interview instead, but the head of the IRB felt this inappropriate and managed to grant access permission without a presentation.

After obtaining all access permissions, I thought I was ready to start my fieldwork as scheduled.

4.2.2 Second stage: Further unexpected hurdles to obtain access and ethical permission

The second stage of the access process illustrated features of each hospital organizational context. This stage of obtaining access permission was unexpected, and something for which I had not planned in my schedule. Upon upgrading to PhD, I returned to Jordan to start fieldwork as scheduled. A few days after I arrived in the country, I visited the managers of the hospitals in order to introduce myself, my project, and to present the obtained ethical permissions from the higher committees. In the military hospital, the manager refused to let me start my fieldwork on time, although I showed him the permission from the higher command in the JRMS. He insisted that the command send him a decree that permitted me to conduct my research via the military mail. I returned to the higher command in the JRMS in the capital Amman and informed them about this issue. Members of the higher command were cooperative, since I already had the access permission, and I had my proposal ethically approved. They sent an order to the manager of the military hospital via the military mail asking him to ease my mission in the hospital.

Two days after the order was received by the hospital manager I re-visited the hospital and talked to him and the nursing manager about my project. They granted me permission to visit the heads of departments and staff members in the surgical wards. I visited them twice in the first week, introduced myself, and described my research to all staff who were available. After that, four visits were carried out in both wards on different shifts to obtain consent (Appendix Three. B).

During the same period, I contacted the manager of the public hospital who shocked me by saying that the access permission that I had from the ethical committee of the Ministry of Health was incomplete and informed me of the existence of another internal ethical committee in the hospital, which needed to study the proposal for a second time. I submitted my study proposal, including the amended topic guide to the internal ethical committee as asked.

Another problem I faced in the public hospital was that the people responsible for nursing administration asked me not to use my informed consent forms (Appendix Three.A) to obtain the permission of patients. Instead, they asked me to use pre-prepared consent forms they had designed for research purposes (Appendix Three, A.1). They also asked me to keep a copy of the consent forms of each participant, whether a patient or a professional, in the archive of the nursing administration department. I considered this unacceptable as it would destroy participants' confidentiality and anonymity. I therefore asked for a meeting with the head of the internal ethical committee, and discussed the matter with him. At the beginning, he

was insistent that “this is the policy”. I explained to him my concerns that it would seriously destroy participants’ anonymity and confidentiality; and might inhibit patients’ and staff participation in my research. After our discussion, the head of the internal ethical committee agreed for me to give a copy of the informed consent form to the participating professionals and keep the second copy myself. No third party would receive a copy of a professional’s consent forms. However, a copy of the consent forms of patients was asked to be attached to their medical files.

The head of the ethical committee in the public hospital said that he would also discuss this issue during his first meeting with the manager. This has positive implication for researchers who will conduct their research in this hospital in future.

After all of these steps, the ethical approval from the internal ethical committee was granted (Appendix Two. C.1.1). Ethical permission from the internal committee of the public hospital, and the whole ethical permission process took a total of four months for both hospitals.

4.3 Sampling

Qualitative research does not commonly aim to identify a statistically representative sample of people, or enhance the statistical generalizability of findings (Pope *et al.*, 2002). Rather, “the sampling strategies used in qualitative research are purposive or theoretical” (Pope *et al.*, 2002: 149), in order to enhance an in-depth and holistic understanding of the studied issues (Miles & Huberman, 1994; Lincoln & Guba, 1985).

For this research, purposive sampling was used. Purposive sampling is a non-probability sampling technique, “where participants are selected on the basis of having a significant relation to the research topic” (Seale, 2004: 199). Purposive sampling was selected for the following reasons. Firstly, prior to conducting the research, I had a limited knowledge of the potential participants in the study because the research occurred in changeable settings where the populations were also changeable. Thus, random sampling in advance was not possible (Miles & Huberman, 1994; Lincoln & Guba, 1985). In addition, I did not plan to use random sampling from the start as it did not correspond with my research approach.

Secondly, purposive sampling, along with continuous transcription and data analysis in the field, enabled me to sample participants until I reached the ‘point of redundancy’ (Lincoln and Guba, 1985: 202) or the point of saturation when no further new data emerged (Lincoln & Guba, 1985; Glaser & Strauss, 1967).

4.3.1 Hospitals

Two hospitals of the JRMS and JMoH were purposively selected meeting the criteria of multiple-case study design, as mentioned previously. According to Yin (2003b: 46), case studies may be classified as single when the study contains one case, or multiple when the study contains ‘more than a single case’. Multiple cases (surgical wards) were selected because of the different organizational contexts, i.e. military, public, which existed within the same socio-cultural Jordanian setting. Box (3) further explains the key reasons for the selection of these sites.

The public hospital² that was studied is a large one in Jordan. It had over 200 beds (JMoH, 2011b), departments of all medical specialities, and surgical units classified according to the patients' gender. Both of these are managed by the same head of the department (S.N P.50).

Box 3: Key reasons to select the two studied hospitals

- The majority of Jordanian patients are referred to military and public hospitals because these offer free services (covered by military and government health insurance) or low cost services compared to those offered by private hospitals (Al-Hassan & Hweidi, 2004). It can therefore be reasoned that the patient make up of these hospitals is more representative of Jordanian society than that of private hospitals which only rich or high status individuals can access.
- Each selected hospital included at least two general surgical wards (one male and another female). This meant that four cases could be studied. Adding two more by also including a private hospital would have expanded the sample but was not viable in terms of time, money, and data management.
- Both of the hospitals studied were large, but peripheral in that they were located outside the capital. They are therefore not subject to the direct inspection experienced by most hospitals located in Amman. Being less used to frequent direct inspection encouraged nurses and physicians to practice as they practised routinely, rather than as they assumed the inspection committees would want.
- Both hospitals are located in the same region as the researcher was based, leaving the chance open to conduct research and observation at any given time, day or night.

The studied military hospital has about 500 beds. General surgical units are classified according to patient gender, and each is led by a different head of department. Heads of departments are nurses with high rank and substantial experience of working in the JRMS.

² For confidentiality purposes, the place of both studied hospitals is not mentioned because of being easily identified.

4.3.2 Universities

As well as observing practice in hospitals, it was felt that an examination of nursing 'knowledge' might be relevant and informative. Thus, the initial design planned to look at nursing training by conducting interviews and a document review in two Jordanian Universities. However, constraints on the final size of the study, and the estimated difficulty of managing collected data, limited the final design to reviewing syllabuses from two nursing faculties to verify issues relating to nursing education and training, which emerged in the course of the fieldwork.

One Government University and one Private University were selected purposively, each had a faculty of nursing. As an employee of the Private University which was chosen for study I have a good working relationship with key persons, and this eased the collection of data. It could be suggested that working in so familiar location could leave the study open to bias, but given the nature of the data collected from the schools of nursing in both hospitals using document review, there was little opportunity for this to have an impact. The Government University was selected because it is a university with a nursing faculty. It was also near (45 minutes) the studied hospitals. A map of the location of case studies cannot be provided because the hospitals and universities could be easily identified.

4.3.3 Participants

Purposive sampling was also used with patients, patients' relatives, nurses, and physicians. These groups of participants were chosen to capture the perspectives of all those involved in patient pain management.

- **Patients:** Surgical patients who had undergone surgery at the time of the research and were aged eighteen years or over were invited to participate in the study through interviews and observations. However, patients who were younger than eighteen years, those physicians and staff nurses reported as too ill, and patients who were transferred to intensive care settings were excluded from the study. The initial design planned to interview 40 patients (20 females, 20 males). However, the total number of interviewed patients was in fact 38 patients (20 males, 18 females) (Table 1). The researcher was not able to interview a further two patients as access permission to the Public hospital expired before this was possible.

Table (1): Number and gender of participating patients				
		Military Hospital	Public Hospital	Total
Gender	Male	12	8	20
	Female	9	9	18
Total		21	17	38

- **Nurses:** Purposive sampling was also used to select nurses as there were many different types of nurses in the hospitals, such as assistant nurses and registered nurses. Those selected to be part of the sample were all registered staff nurses (S.N) with the Jordan Council of Nursing, and had

completed a BSN in Jordan. Assistant nurses, or nurses who worked as porters, were not included. Porters are nurses whose main job is to move patients from one ward to another, or to and from the operating theatre. They may also transport routine blood samples to the laboratory. It was assumed that given the nature of the jobs they carried out (e.g. measuring vital signs, tidying beds, and transporting patients) both assistant nurses and porter nurses would play little or no role in patients' pain management. Thus, a decision was made to exclude them from the research sample. Twenty nine registered S.Ns were observed and interviewed during the fieldwork (Table 2).

Table (2): Numbers and characteristics of participating nurses					
Hospital	Ward		Gender		Total
			M ♂	F ♀	
Military Hospital	S.M*	Observed Only [∞]	3	10	13
		Observed & interviewed	2	8	10
	S.F*	Observed only [∞]	0	8	8
		Observed & interviewed	0	7	7
Public Hospital	S.M	Observed only [∞]	4	4	8
		Observed & interviewed	3	3	6
	S.F	Observed only [∞]	0	7	7
		Observed & interviewed	0	6	6
Total (♂+♀)		Observed only	7	29	36 [∞]
		Observed & Interviewed	5	24	29 [∞]

* **S.M:** Surgical Male patients ward

* **S.F:** Surgical Female patients ward

[∞] The number of "nurses observed only" is > nurses "observed and interviewed" because some nurses had left for either vacations, maternity leaves, training courses...etc before being interviewed.

Table (2) shows that there were no male nurses on female wards, and that the majority of nurses who worked on male wards in the military hospital were females.

In both hospitals, two female staff nurses refused to participate in the study. Both of whom were working in the military surgical female ward. Since I could not observe what they did, I observed other nurses on these shifts; or in some instances conducted my observation episodes on alternative shifts.

- **Surgeons:** Surgeons at both hospitals were invited to participate in this study (Appendix Three. D). Thirteen surgeons from both hospitals agreed to take part in the study, and were thus observed and interviewed. All were of a relatively long expertise in their field. Some surgeons had nine years of experience, and others had up to 40 years.

All participating surgeons were male (Table 3). The majority of those who refused to participate (n=10) were from public hospitals, and their unwillingness was largely based on my refusal to reveal the results of the fieldwork I had already completed in the military hospital. In the military hospital, some surgeons did not take part (n=3) because they were obliged to travel with the military in mobilized hospitals around the country or abroad at various times.

Table (3): Number of participating/non-participating surgeons in each hospital			
	Military Hospital	Public Hospital	Total
Participated	7	6	13
Refused participating	3	7	10
Total	10	13	23

- **Family members (Relatives):** Family members who were aged eighteen years or over and agreed to take part in the study were selected (Appendix Three. C). Relatives who accompanied patients during their

hospitalization were invited to participate in the research in the aim of understanding their perspective. Interviews were initiated until reaching the point of redundancy or saturation, when the researcher found that no new data was being added. In total, interviews were conducted with 20 relatives (Table 4).

Table (4): Gender of participating relatives of patients interviewed in both hospitals				
		Military Hospital	Public Hospital	Total
Gender	Male	5	3	8
	Female	6	6	12
Total		11	9	20

4.4 Contacting potential participants of case studies

Before communicating directly with nurses in the military hospital, I contacted heads of departments to show respect to their positions, and to explain my research. I offered assurance that I would not cross their authority and that I would not talk to staff without their permission. I made it clear that I felt that they had the right to refuse me access to their departments even though I had been given permission by the higher committee. This step showed my respect for their authority, and that I was not looking to pressure them into allowing me to operate in their department. When the heads of departments in the military hospital indicated they were happy for me to proceed, I gave them a week to talk with their staff about the nature of my activities. The main points discussed during the introductory meeting with the heads of departments are included in Box (4).

Box 4: Key points discussed with heads of departments and nurses during the preliminary visits.

- I clarified and confirmed my role, and the nature of my research. I established that I was not there to evaluate staff, making clear from the beginning that I was not going to provide any information of their staff's performance.
- I made it clear that it is not my right to inform them of the identity of those staff nurses who agreed to take part in my research. Only the staff nurses themselves have this right.
- I confirmed that the identity of staff members who agree to participate in the research will be known only to me. My supervisors will only be able to read the raw data anonymously. No third party has the right to see the raw data, records, names, or any other information collected. Third parties will only be able to read the final report upon completion of the research. This final report will not include any names or any other information that may expose participants' identity.
- I stressed that I would not be working with nurses as a nurse, but would be spending time in the department as a researcher, and that I might therefore be seen at any corner or space in the departments within a pre-planned schedule. I would, however, participate in some duties if asked for help, or in life threatening conditions of patients where I could be of assistance.
- The head of departments asked me to wear a white laboratory coat, and a tag clarifying my identity and name.
- At the beginning they asked me to give them my observation schedule which showed the time of observations. I expressed my reservations, as the knowledge that they would be observed may make nurses prepare themselves for the observation. In addition, I expressed that the schedule would continuously be subject to modifications according to updated fieldwork needs. The head nurses understood these point, and were cooperative.

When I returned the following week to meet nurses they were expecting my arrival. I felt that my decision to ask that heads of departments discuss my presence with their staff first had been a wise step as it eased the way for me to introduce myself to the nurses. Nurses in both surgical wards were contacted and visited informally one month before starting the fieldwork.

Six visits were carried out in total, on different shifts so as to guarantee meeting nurses who worked at different times. In the military hospital, staff gathered in the head of departments' offices, and I talked to them for about 30 minutes about my study. I then handed them an explanatory information sheet, and the consent form. They asked questions, and I answered. Some of them agreed immediately to take part in the study, and some asked for time to decide whether to take part in the study or not.

Similar steps to negotiate access were undertaken in the public hospital. Both the male and female surgical wards had the same head of department. However I faced a significant problem when she insisted that in exchange for her full co-operation I must provide a written report about her staff's performance during the observations. This situation required me to be assertive to ensure I maintain participants' confidentiality:

"The head nurse (H.N P.50) asked me to provide a report about what happens during my presence in the surgical wards, about the job nurses do and any defects in their performance. She said that she would benefit from my reports in promoting nurses' performance. I informed her that my work with staff nurses is confidential and that I could not reveal any data I observe or collect during my presence in both surgical departments. I also said: "...The only report I can give to you and to the heads of departments in the other hospital is a final report that will also be submitted to the Ministry of Health and hospital administration upon finishing my PhD, which will include some problems and suggestions. But even this report will not include any specific names, or incidents as such inclusions would destroy participants' confidentiality." (Preliminary visit; P.H; informal interview)

It was later made evident that the head nurse inspects her staff covertly, as will be shown in Chapter Six (Section Two, Subsection 1).

4.5 Challenges related to the process of obtaining Consent

Although all types of research involve ethical tensions (Guillemin & Gillam, 2004), conducting qualitative research produces specific ethical challenges because of the presence of the researcher in the participants' life and surroundings (Holloway & Wheeler, 1995). In health research, especially that involving patients, researchers face ethical challenges which arise from patients' "vulnerability and lack of power in the clinical situations." (Holloway & Wheeler, 1995: 223).

Constructing an ethical framework for any clinical research demands adherence to, and respect for, participants' autonomy (Beauchamp & Childress, 2001); and an in-depth consideration of their vulnerability. Further, the dual roles and position of a nurse-researcher must be reconciled with the need to maintain empathy, objectivity, and the consent process (Krouse, Easson, & Angelos, 2003; Holloway & Wheeler, 1995).

Respecting a participant's autonomy requires that before they can give their informed consent a participant is fully aware of the research aim, and potential harm and benefits. Informed consent is a "two-way communication process between subject and investigator" through which participants grant their voluntary, explicit agreement to take part in research, upon their full recognition of what the researcher seeks to know, "without threat or undue inducement" (Sieber, 1992: 26).

All participants were informed at first contact about the nature of the research and its aims. I subsequently met with the nursing staff members in

the surgical wards of both hospitals and explained the research aims. And finally, I registered nurses who volunteered to participate out of an interest in the research, who also signed informed consent forms.

The same steps were undertaken with patients and their families twenty four hours prior to their surgery. If admission was less than twenty four hours before surgery, then requests for participation were submitted no less than eight hours before the operation. Meeting patients prior to their surgery provided them with the opportunity to decide whether to participate or not. However, if the patient was admitted on the day of the operation, he or she was asked whether they would like to take part in the study on the first, second, or third days postoperatively. They were not asked to participate on the day of the operation postoperatively, and were given the chance to decide freely. In other words, patients were recruited for interviews either the day before their surgery, or between the first and third postoperative days.

All participants were informed that their involvement was voluntary. It was made clear to patients that they had the complete right to withdraw from the research at any time without it influencing their care.

Confidentiality was assured and personal data was kept safely. A matching list of names, numbers, and other personal data was kept separate from interview records (*see* Holloway & Wheeler, 1995). Upon collecting data, transcripts were completed as soon as possible, and numbers and codes replaced names to maintain the confidentiality of participants. When word document files of interviews and observations were sent via the internet to

my supervisors, files were encrypted and secured with a password that was sent separately.

However, during my fieldwork, challenges related to ensuring the maintenance of informed consent continually arose (see Orb, Eisenhauer, & Wynaden, 2000).

Firstly, I faced difficulties maintaining the informed consent of patients and relatives (Lawton, 2001), as the wards in which I was working had a high turnover rate of patients in both hospitals. Some researchers, such as Holloway & Wheeler (1995) have suggested that an appropriate way to overcome such a problem is to continuously enquire of patients whether they are still prepared to take part in the research. However, continuously informing participants that the investigator is collecting data has two disadvantages. Firstly, it may affect participants' behaviour and therefore impact upon the validity of the collected data (Lawton, 2001). Secondly, participants may "get fed up with being repeatedly asked if they want to continue to participate" (Wiles, Crow, Charles, & Heath, 2007). To overcome these problems I asked patients if they agreed to be involved before beginning each observation episode. In addition, I put up posters in clear places in the observation areas to inform others that the research was in process, so as to ensure that anyone could refuse to be observed (Appendix Four):

"The first thing I have done is post signs on both the inside and outside of the ward main door. On it was written that "a nursing research study is in progress...observation will be done in the area of this ward. Whoever needs further information or does not wish to be part of this observation may contact the researcher personally"
(Observation (1): My field notes: S.M; M.H; Shift (A); 7:15am)

This technique was applied only in the first observation episode, after which I modified my approach as many new patients were being admitted during observation hours. Some of these patients I managed to contact and others I could not speak with because of the large number of discharges and admissions:

"Many patients were discharged. During this time, many also were admitted, and I was left with the problem of having to ensure the consent of patients who were admitted during the observation. This made me somewhat exhausted. From this point forward I checked the admission book for every new admission, talked to patients newly admitted and took their verbal consent. So far no one has refused to be involved in the observation scope." (Observation (1): S.M; M.H; Shift (A); 9:30am)

"10:40 am: Patients turnover is high. Some patients who I have met yesterday with fresh operations were discharged this morning." (Observation (14): S.M; M.H; Shift (A); 10:40am)

Reflecting on this situation, I decided to put a poster over each patient's bed. This poster outlined in detail the subject and aims of the research and my contact numbers and addresses. New patients could read this poster and reply to me personally or via their relatives. This technique also allowed me to overcome the problem of obtaining the consent of the huge number of visitors who changed every few minutes in the zone of observations. The presence of individuals who have not given consent in the field of observation was a problem that other researchers have reported (Mulhall, 2003). I talked to all heads of departments in both hospitals to ensure these posters were kept in their places until I had finished conducting each observation episode. Henceforth, these posters were put on the main door of the wards on which I was working, on the door to each patient's room, and over the head of all beds:

"I checked the ward half an hour before. Many patients I saw yesterday have been discharged. The turn over of patients is very high and some of the new admissions are not documented in the admission book. It is very important that all patients are informed about the research and observation. I decided to display a poster, in large font, explaining that research is being conducted on the ward, providing some points to clarify the nature of the research. This paper will be stuck on the door to each room and above the head of each bed. The poster makes it clear that anyone who does not want to be involved in the research, or has any questions about the study should talk to the researcher." (Observation (2): Note (p.3); S.M; M.H; Shift (B); 2:25PM)

Each time I conducted an observation episode, I put up these posters, and took them down when I finished. It was important to remove the posters when I finished each observation episode in order to avoid confusing participants about my presence. It was beneficial to put the posters up at the beginning of each observation episode, so that patients, especially those who were illiterate, could ask me about the posters. To do this work, of putting up and removing the posters, I had to be in the hospital two hours before the scheduled time of each observation, and one hour after each observation. Hence, the total duration of each observation episode was about five to six hours, of which 2-3 hours was spent conducting observation. Only three female patients and their relatives refused to be observed during the observation stage in the female ward of the military hospital. When asked to explain the reason for their refusal, they said that they feared participation could cause them trouble with nurses.

Because the turnover rate of patients in the wards of the second hospital was also high, the technique of putting a poster over the head of each bed was also applied:

"6:45 am: Similarly to how I have done in the previous hospital, today, I have placed a poster on the top of each bed clarifying that I am conducting a research observation, and asking that any patient or relative who refuses to be observed to contact the researcher in person, or via my contact numbers."(Observation (1): S.M; P.H; Shift (A); 6:45am)

However, in the public hospital, I faced more challenges when I put up the posters. Each time I collected the posters, I found many comments written on them. In addition, although I had already received permission from the head of the departments in the public hospital to display them, me putting up posters provoked a wave of unsatisfied responses, as nurses told me during a number of formal and informal interviews:

"While he was writing nursing notes, the S.N said, '...when you put stickers in patients' rooms and in the corridor about your research, some nurses write some 'bad' comments...some of them wondered why you are doing this study. Maybe because we are not used to the way in which you are conducting your research ... I think that in hospitals where there are many defects, people in the administration and their 'spies' try to create difficulties for researchers, as they do with you... I heard that your beginning in this hospital was not easy, and was challenging. Other researchers were not challenged in this way because they did not spend much of their time in the hospital... They distributed questionnaires and left, and after many days they returned to collect them. Honestly, most of those questionnaires were filled out by hospital maids. We did not have enough time to read and to fill them out..." [Observation (15): S.N P(56); M; S.M; P.H; Shift (B); 5:10PM)

4.6 Data collection methods

4.6.1 Non-participant observations

Observation, interviews, and document reviews are the most common data collection methods used in qualitative research (Pope *et al.*, 2002).

A well scheduled and conducted observation gives the researcher the opportunity to uncover the behaviour of an individual, as well as what is

happening in the field (hospital wards) in routine daily life (Darlington & Scott, 2002; Pope *et al.*, 2002). In particular, observations are useful for studies that are conducted in organizations if a greater understanding of what is going on in a certain area or setting is the aim (Pope *et al.*, 2002). In addition, they enable the collection of data while health care professionals, as well as patients, are occupied without being interrupted (Darlington & Scott, 2002). In other words, the observation method gives a researcher the opportunity to observe events and activities within the time frame and context they usually occur (Lincoln & Guba, 1985).

In addition to these advantages, the observation method helps an understanding of the interactions that occur between health care professionals, professionals and patients, professionals and family members, as well as between family members and patients, and vice versa. There is also a greater capacity to include consideration of non-verbal expressions and unconscious behaviours (Lincoln & Guba, 1985).

Observation was utilized to capture the nature of interactions between participants, the spaces in which interactions took place, and the boundaries that established what was prohibited or permitted in terms of interaction. Observation was begun using the ideas drawn from the literature review, but was also expanded to enable new variables to be collected. Initial observations established certain categories of data, and more focused observation took place in later observation episodes, along with continuous reflection on the progress. The point of redundancy was reached (Lincoln &

Guba, 1985) in some settings but not others because the period of access permission expired.

I conducted observations as ‘observer-as-participant’ (Burgess, 1984) because I did not participate in nursing activity but maintained “superficial contact with people being studied” (Waddington, 1994: 108) through informal interviews.

This position was selected for many reasons. Firstly, each observation episode continued for two to three hours (Bucknall *et al.*, 2007; Manias, Bucknall, & Botti, 2005), limiting my ability to participate in nursing activities and collect data at the same time. Secondly, the wide spectrum and variety of nursing activities would have drawn my attention away from the focus of the study. However, because of the duality of my identity as a nurse and a researcher, I intervened in cases of emergency to avoid patient harm (McCarthy, 2006) (Chapter Three, Subsection 4.11.1: B).

In total the observations lasted about 123 hours in surgical departments in both hospitals, and took a total of three months on different shifts (Table 5). The moderate engagement with studied cases was useful as it enabled me to become more familiar with the contexts of the situations I was observing, it also helped me focus my observation on to issues of interest, and at the same time promoted the depth of the collected data (Lincoln & Guba, 1985). There are potential problems with long observations, and I personally think that where a researcher spends a long time conducting observations they risk normalizing events through habituation. This was minimized in my case

however, because my time was split between four wards, and so the time spent in each ward was relatively short.

Many reasons determined when to end observations, such as reaching the point of redundancy or finding that there were few emerging issues. In addition the anticipated end of the period of access permission forced me to move to another ward to finish conducting observations. This occurred in particular in the military hospital, although the access permission was extended for a month (Appendix Five).

The observation episodes took place for two to three hours during different shifts and at different hours during each shift (Table 5) to ensure capturing all of the different types of events. As a nurse, my prior experience suggested that some events may take place in certain shifts but not in others. “Indeed, other front-line medical situations-day and night are quite different” (Hallowell, Lawton, & Gregory, 2005).

Table (5): The hours of shifts at both hospitals			
Shift	Military hospital	Public hospital*	Total hours of observations
Shift A	7:30 am -3:00 pm	7:30 am - 3:00 pm	52h
Shift B	2:30 pm - 9:30 pm	2:30 pm - 9:30 pm	49h
Shift C	9:00 pm - 8:00 am	9:00 pm - 8:00 am	22h

* Shift (BC): Because of nursing shortage in the public hospital, B & C shifts were merged most of the time, and thus some nurses worked from 2:30 pm to 8:00am next morning. Thus, Public hospital had mainly shift (A), and (BC).

My inability to be present constantly during all the shifts was an expected issue, and a reason for the use of document review as another data collection method. Document reviews help to collect data about events when the

researcher is not present, and can provide information about past events (Yin, 2003b) although the accuracy and authenticity of recorded data is not always guaranteed (Forster, 1994) and this was indeed an issue in this study (Chapter Five, Section One).

In both hospitals I did not reveal the exact timing of the observations, as mentioned earlier, to avoid altering behaviours, especially in the late hours of night shifts. Some nurses asked me frequently for the schedule of my observations, but I always explained to them that I could not reveal that schedule, especially given that some observation times might need to be changed where there is a need to observe a certain shift more than another.

Utilizing observation as a data collection tool was not simple and straightforward. Many challenges were faced because of my gender, role as a researcher, or my background as a nurse (Chapter Three, Subsection 4.11.1). As a stranger, or a nurse who did not usually work inside the studied hospitals (Darlington & Scott, 2002), I was not welcomed in one of the studied hospital and initially faced some difficulties in accessing nursing practices on patients, especially those involving male patients. This challenge was more apparent, especially as I did not participate fully in nursing activities in the field as mentioned earlier. Although my informal visits to the hospitals before commencing the fieldwork had helped with this challenge in the military hospital, and eased the building of rapport with the nurses, physicians, and key persons in the administration, it was less helpful in the public hospital and I faced particular problems with the head of departments.

Another challenge that I faced was the inability to observe concurrent events at the same time.

I used a specially designed research sheet to capture and write down field notes during observations (Appendix Six). This sheet included specific spaces to record observation data and others for my reflections and interpretations. This was because the integrity of data collected through observation is challenged by the risk of subjecting the data to the researcher's own interpretations (Darlington & Scott, 2002). Some researchers such as Darlington and Scott (2002), and Lincoln and Guba (1985) have suggested that such a risk may be minimized by establishing a greater familiarity with the context being observed through persistent observation and engagement. However, such persistent engagement, as argued previously, might lead to habituation and normalizing events by the researcher.

Although observation is a useful method to collect information about people's behaviours, and about both verbal and non-verbal interactions, the inability to detect the real intentions behind some behaviours or events is a weakness (Bryman, 2008; Lincoln & Guba, 1985). That is, how the researcher interprets what they observe may not be how others interpret it. Thus, both informal and semi-structured interviews were utilized to complement this weakness in the observation method. The informal interviews were particularly useful in providing immediate explanations of certain events noted during observations. This will be explained further in the following subsection.

4.6.2 Informal interviews

Since “observation alone cannot tell us why people do the things they do or what the particular activity means to them” (King, 1994: 75), observational practice was supplemented with informal interviews. This data collection method was used primarily to understand the social meanings of participants’ actions from their own perspectives (Hutchinson & Wilson, 2001; Melia, 1982). These informal interviews took place after events had occurred during observation episodes.

The topics of these interviews were not set in advance, but were based around participants’ responses to emerging issues (Melia, 1982). As this occurred, previously unrecognised issues emerged, were expanded upon, and enriched my findings:

“Interviews, generally informal in nature, augment these observations and serve to clarify the meanings attributed by the participants themselves to a given situation,” (Hutchinson & Wilson, 2001: 216).

These informal interviews were processed and analysed along with observation notes and the resultant ideas were tested in the later semi-structured interviews to gain a more comprehensive understanding of the emerging issues (Melia, 1982).

Data collected in informal interviews was recorded under a separate title within the observation notes, and was processed in the same way. Consent for undertaking these informal interviews had been included in the consent obtained for the observations.

Another advantage of conducting informal interviews was the training they could provide for responding to unexpected responses from participants:

“Several weeks ago, I was surprised when one of the patients said that the Qur’an should not be used for the healing of pain since it is a holy book, not a drug. I could not hide my surprised facial expressions, but today, when I heard a similar statement from another patient, I could handle it and asked him to clarify his opinion” (Observation(10); My Notes(P.46); S.M; M.H).

4.6.3 Semi-structured interviews

Interview is a data collection method that gives the researcher the opportunity to collect data from the perspective of the interviewee (Hutchinson & Wilson, 2001) as well as to understand why the interviewee “comes to have this particular perspective” (King, 1994: 14).

Interviews can also give access to data, such as participants’ views, and attitudes that might not be anticipated using other methods such as observation or document review (Bryman, 2008; Pope *et al.*, 2002). An example of this is a patients’ pain severity and related distress as expressed by the patients themselves. In addition, an interview is characterized by its flexibility as it can be used almost anywhere, and its “ability to produce data of great depth... and most research participants feel comfortable [with]” (King, 1994: 14).

The decision was made to use semi-structured interviews, rather than structured or open interviews, because I had a set of assumptions in advance that were drawn from the literature review, and I needed to explore these assumptions from the perspectives of participants. In addition to this, informal interviews and observations had yielded other issues that were best

understood through semi-structured interviews. In summary, these interviews shed light on certain pre-determined issues and also left the door open for new issues to emerge, as Pope *et al.*, have noted, “semi-structured interviews are typically based on a flexible topic guide that provides a loose structure of open ended questions to explore experiences and attitudes” (2002: 148).

Thus, the interviews were conducted after finishing the observation of both departments of each hospital. However, great attention was paid to the timing of interviews with heads of departments and staff:

“Next week I will start conducting the first interviews in the military hospital in the surgical male ward. I decided to postpone the interviews of the heads of departments until I have finished interviewing the other staff. I do not want heads of departments to know the nature of the interviews and the questions as I fear that they may instruct nurses how to answer the questions. Many nurses were satisfied when they knew that they would be interviewed before the head of departments as they did not want them to interfere with their answers before they are interviewed. I explained to the heads of departments that as they have administration expertise I want to interview them at the end so that I can ask them about any administration-related issues that emerge from my interviews with nurses and patients.” (My Notes (P.68); M.H)”

As mentioned previously, interviews were conducted with nurses, doctors, patients and their relatives to make sure that issues were explored from various perspectives, and to avoid capturing a partial view of a certain issue (Allen, 1997). The duration of patient interviews ranged between 20 minutes and 35 minutes depending on the patient’s case, overall health condition, and age. Older patients sometimes took more time to answer questions because they talked more extensively about issues and occasionally did not give direct answers. Patients were interviewed at their

bedsides and curtains were closed if available, although in some cases, the noise and presence of some relatives caused interruptions. Some patients did not want to talk in their rooms in the surgical male ward in the military hospital, and asked to be interviewed in a private room. Where this was the case I booked the resident doctors' office in the same ward, and interviewed them in private. For example, a patient who refused to be interviewed unless it was conducted in a private room was interviewed in this office, and he also asked that his mother be present.

Among nurses and doctors in the surgical male ward of the military hospital interviews took from an hour to 1.5 hours, especially with nurses who had many things to say. The interviews were conducted in the resident doctors' office which was unoccupied most of the time, and arrangements were made with the head of department.

Staff members on the surgical female ward of the same hospital were interviewed in the library, and, at the request of the head of the surgical female ward, in the resident doctors' office as no spaces for interview were available in this ward. Both the library, surgical male and female wards are on the same floor of the hospital.

In the public hospital, the head of surgical departments asked me at the beginning to interview nurses in her office in her presence telling me that she would be so busy that she would not hear any word of the interviews. I refused and preferred to select another site for interviews. Nurses nominated the nursing dressing room of each surgical department as the most appropriate place.

When conducting interviews, I prepared intensively; I kept eye contact with the interviewee when using a digital recorder, or wrote down brief notes when some interviewees refused to agree to the recording of their interviews (n=69) (Table 6). It was important for me to observe non-verbal expressions and listen closely to verbal responses in order to capture the interviewee reaction when talking about certain issues. In addition, it was important to check the digital recorder for battery status. During all interviews, I had a seat facing the interviewee and I paid attention to all of my movements and involuntary facial expressions. At all times, I wore a head cover, which I wear usually, and talked in a moderate voice since Jordanian traditions discourage women from laughing or talking loudly, especially with strangers, even when expressing their pain (Abushaikha, 2007).

- **Planning the interview structure and themes**

As mentioned earlier, the topic guide questions were developed from the literature review that took place in advance; and it relied on both the possible issues which I thought might emerge - based on a professional familiarity with the Jordanian clinical context - and on issues which arose from the pilot study. However, the topic guide was left open for some modifications that were added after observation and informal interviews were completed.

The initial topic guide I developed was sent to a Jordanian Professor, with the agreement of my supervisors, to check the accuracy of the translation from English to Arabic language. The Professor replied that the translated copy of the topic guide was understandable and efficient.

The ethical approval for the military hospital allowed amendments or additions, and did not restrict any changes. However, permission for this purpose from the public hospital had to be obtained from the internal ethical committee. This was granted after an informal discussion with the head of the department.

The preliminary topic guide was divided into four sections according to the interviewee's status as patient, relative, nurse or doctor. The main themes are presented in Appendix Seven.

- **Pain scales used: Numerical Rating Scale (NRS)**

The interview guide for patients included questions about their pain intensity using the 11-part Numerical Rating Scale (NRS 0–10). For all patients, the ruler was always displayed in vertical to facilitate understanding (Li, Liu, & Herr, 2007). I asked further questions related to the distress caused by the pain and the progress of pain intensity since the operation (Appendix Eight. A).

This research used the NRS to measure patients' pain intensities because of its ease of use (Von Baeyer *et al.*, 2009), and because it provides high reliability and validity in comparison to other scales, such as Visual Analogue Scale (both Horizontal and Vertical line orientation), Visual Descriptor Scale (VDS) (Gagliese *et al.*, 2005), and Face Pain Scale Revised (FPS-R). It is also more commonly used in clinical practice in Western settings (Li *et al.*, 2007). In addition, the NRS has been validated in Arabic, and thus the validated Arabic Version has been used.

Although this study did not aim to test the psychometric criteria of NRS, many precautions were taken to limit interference with the reliability of measurement. For example, all patients were interviewed by the researcher herself, which standardized administration (Davidhizar & Giger, 2004). However, some uncontrolled or external factors did intervene, such as those related to the assessment setting, as at the request of some of the patients, relatives were present during the interviews. This factor seemed to influence some patients' willingness, especially men, to report their pain scores, especially in the light of the culture of stoicism that seems to be suggested by this research. In addition, it is believed that the fact that the researcher being female might have inhibited the willingness of some male patients to communicate their pain intensities accurately for fear of threatening their pride and masculinity. Evidence of this is presented in the findings chapters.

4.6.4 Document review

A document review is widely used as a method of data collection in the social sciences, organizational studies, history, anthropology, sociology, and linguistics (Forster, 1994). The document review is a useful tool to collect data that is readily documented and available (Lincoln & Guba, 1985). Collecting data using this method might be at a low risk of researcher's and participants' reactivity (Bailey, 1982). The "reactive effect is a term used to describe the response of research participants to the fact that they know they are being studied" and so it results in altered behaviours (Bryman, 2008: 698). However, it is still possible that other forms of bias may intervene. For example, although the researcher proposes that data, for example patients'

records, is recorded accurately, the actual accuracy of the recorded data cannot be guaranteed (Forster, 1994).

The document review for the purpose of this research included primarily patients' medical profiles, including nursing notes; doctors' progress notes, and orders regarding prescribed pain medications; documented pain assessment; and, if any, patients' pain conditions and the actions applied to manage pain and reassessment.

In addition, handbooks and syllabuses of relevant modules in the Nursing Faculties were reviewed to identify what was taught regarding pain, pain management approaches, types of knowledge regarding pain, adopted pain models, and other topics related to professionals' interventions and relations. The organizations' philosophies were reviewed to see if there is anything resembling an institutional approach to dealing with pain and pain management, in addition to looking for adopted pain management guidelines and policies, if any, and other policies regarding professional jurisdiction in dealing with patients. Finally, hospital and organizational (such JMOH) legislation regarding drug protocols, especially opioids, and nurses' job descriptions were examined.

Reviewing these documents helped explore professionals' pain management practices, in addition to other behaviours such as the inaccurate documentation of some events, and the effect of some policies on the approach of nurses to the administration of painkillers.

My previous experiences working in a Jordanian public hospital for six months and training in two military hospitals during undergraduate study

suggested to me in advance that the data I needed would be available in these types of documents. In the words of Lincoln and Guba (1985): “If one knows how the world works, one can imagine the tracks that must have been left by the action...if one knows one's way around the world or records, one knows where to look for the tracks” (p: 278).

4.7 The Language of the research

Both the informal interviews and semi-structured interviews were conducted and later transcribed in the local form of the spoken Arabic language. Colloquial Arabic was used because all people use it in their daily life. Using the Classic Arabic language (Chapter Two, Subsection 4) in such settings as I was working in would have provoked people's humour and would have made me appear rather strange.

It is worth mentioning that some words used in colloquial Arabic are not present in Classic Arabic, and it was therefore important for me to transcribe responses as they were spoken by participants to keep their full richness; and to avoid distortions of meaning that may have arisen in translation from classic Arabic to English. Instead, the participants' spoken words were translated directly to English.

4.8 Preparing data for analysis

4.8.1 Transcription

Collected data was transcribed as immediately as possible, and an effort was made to achieve this on the same day with my reflections on the setting, events and data itself. Transcribing as I went along saved time later when

the fieldwork was terminated (Lincoln & Guba, 1985; Glaser & Strauss, 1967) and avoided loss of data that would occur when attempting to recall an occasion a long time after.

All 100 interviews, both digitally recorded and non-recorded (Table 6), and 123 hours of observation notes and informal interviews were translated and transcribed. The recorded interviews were transcribed first hand written in their original language, and were then translated and typed into a computer. The non-recorded data, including the observations and informal interviews, and semi-structured interviews were hand written during fieldwork, and at the time of transcription, they were translated and word processed onto a computer.

Table (6): Number of participants who accepted or rejected digital tape recording of interviews in both hospitals					
	Military Hospital		Public Hospital		
	Recorded	Not recorded	Recorded	Not recorded	Total
Patients	10	11	4	13	38
Nurses	7	10	3	9	29
Doctors	2	5	1	5	13
Relatives	4	7	0	9	20
Total	23	33	8	36	100

During transcription, it was important to transcribe every word, not only those related to pain, as I discovered after finishing transcribing data and starting analysis that some apparently unrelated expressions gave indication of some important issue, especially those of cultural dimension. On average an hour's interview took about eight hours to transcribe, translate into English, type on a computer, and insert into a computer assisted qualitative data analysis programme, NVivo 8.

NVivo 8 was used mainly for the purpose of managing, sorting, organizing, and coding data (Fielding & Lee, 1998), as well as organizing established themes, sub-themes, and indexing and retrieving it. This was also undertaken during the fieldwork period.

4.8.2 Translation

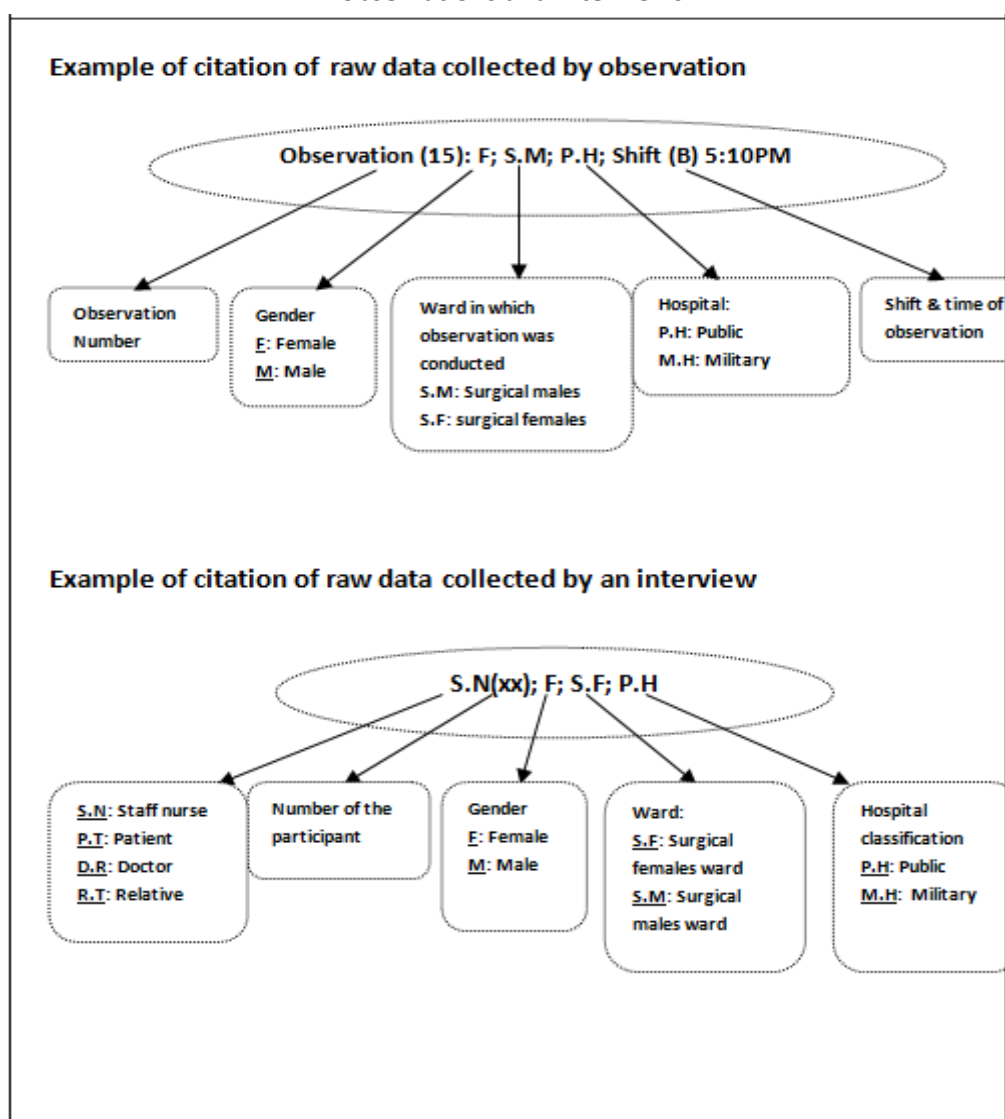
Initially, I arranged with a translator to conduct the translation for some transcripts. I submitted a few anonymous observation notes for translation. The translator had never worked in hospitals, and was working in one of the universities, as an English instructor. However, he did not translate the observation notes including informal interviews literally, and in many instances he had changed the meaning of some sentences and omitted some colloquial expressions. Therefore, a decision was made that I myself carry out translation. Words were written literally whenever the participant said them in English. Otherwise, they were translated as close a match as possible to their original meaning with the attempt to limit the translator's personal interpretations as much as possible. Translation and improvement of my English style was aided by the use of software such as 'White Smoke Enrichment', 'Babylon', and 'Microsoft Word spelling and grammar checker'.

4.8.3 Preserving anonymity in reporting findings

For the purpose of confidentiality, the dates of interviews and observations were not included along with the quotations in this thesis. In addition, the ranks of nurses were not included since such information would allow participants to be easily identified, particularly from the final reports that

will be submitted to the administrators of the studied hospitals. Every quotation will have a label that identifies the method used to collect it; a code for interviewee position, as patient, nurse or doctor; and, if unclear from the quotation, the gender of the observed participant will be included; as well as the shift, the department, and the hospitals where the data was collected. The maps below describe the manner in which citations of raw data are labelled (Figure 3).

Figure (3): Examples of citations of a quoted strip of raw data collected by observations and interviews



4.9 Data analysis

Data analysis is a synthetic process through which the researcher reconstructs collected raw data into ‘meaningful wholes’ (Lincoln and Guba, 1985: 333).

Data analysis in my study was constructed primarily upon interpretative and reflexive reading of the raw data (Mason, 2002), using thematic analysis (Pope, Ziebland, & Mays, 2006, 2000b). Thematic analysis is the most common approach used in health care research (Pope *et al.*, 2006). Using thematic analysis, the raw data was read, and re-read frequently to extract themes.

Themes and categories were derived both deductively and inductively. Inductive analysis means that themes emerge gradually during data collection, rather than being based on a prior assumption or hypothesis. However, since I had some expectations in advance, deductive analysis was also applied. Deductive derivation of themes means that the researcher relies on a prior set of assumptions and theory to derive themes when reading the raw data (Pope *et al.*, 2000b).

Adopting both deductive and inductive analysis enhanced the construction of themes, opening the way for new and unexpected ideas to emerge (Pope *et al.*, 2006). These included the effect of gender on the pain practices of both professionals and patients which imposed itself strongly and unexpectedly; issues of social and organizational surveillance; and the subjugated groups resistance via verbal or physical violence, as shown in chapters of findings.

Thematic analysis started when the first few observation notes were transcribed and the data processed in NVivo 8. Next, a thorough reading was commenced, and codes to label emerging ideas and themes were created. The preliminary codes were revised each time new raw data was coded and as I became more involved in the field, to find gaps in the data (Pope *et al.*, 2000b; Miles & Huberman, 1994). After creating several codes, I moved to the second level, which is pattern coding. “First level coding is a device for summarizing segments of data. Pattern coding is a way of grouping those summaries into a smaller number of sets, themes, or constructs” (Miles & Huberman, 1994: 69).

An index of codes was created to show the component codes of each pattern (theme). This helped with the comparing of incidents in each pattern (Lincoln and Guba, 1985), and with comparing categories and their contents each time data was condensed. Then categories were integrated (Lincoln and Guba, 1985) under the main theoretical insights. “Cross-checking” of major themes in data was completed together with writing analytical memos (Miles & Huberman, 1994: 92). When the development of prepositions was completed, synthesizing of constructions was undertaken to see how they connected with my research questions.

In constructing the themes gradually during the fieldwork, it became clear that although both hospitals had a unique and different institutional context, as my account here about access and ethics has indicated, there were significant commonalities between the cases. Of particular note is that their shared socio-cultural context showed greater influence than organization on

practices and interaction (Chapter Seven, Conclusion). This strong similarity among cases directed me to present data by the themes that emerged across cases, through what is called ‘cross-cases synthesis’ (Yin, 2003b), rather than by reporting each case separately.

4.9.1 Debates regarding when to initiate analysis

As outlined above, the preliminary process of qualitative data analysis was initiated as soon as the fieldwork had begun (Lincoln and Guba, 1985) so as to develop an understanding of what other events it was necessary to observe, or on the time required to achieve saturation. In addition, it was concluded that delaying analysis until the end of fieldwork “rules out the possibility of collecting of new data to fill in gaps or to test new hypotheses that emerge during analysis” (Miles and Huberman, 1994: 50). Early initiation of analysis also helped “organiz[ing] data for later deeper analysis” (Miles and Huberman, 1994: 50).

However, I found some problems with beginning to analyse data with few observations or interviews. I started doing data analysis in the manner of Pope *et al.* (2000b) and as Miles and Hebermann (1994) recommended, i.e. as soon as a few observation notes were transcribed. The preliminary data analysis therefore occurred while fieldwork was still underway. When I finished the fieldwork, I began going through the analysis for a second time, and quickly understood that there was much to do (Pope *et al.*, 2006). I found some differences when comparing the categories produced during fieldwork with those produced at the end. The later analysis was more

comprehensive and integrated, and more theoretically oriented. This might be attributed to many reasons:

- My thinking became more mature after eight months of fieldwork, and thus, a change occurred in the way I viewed the issues.
- More data was considered, enabling a more comprehensive view of themes and contexts.
- The time available for data analysis during the fieldwork was shorter than that allocated to it upon finishing the data collection. After completing data collection; translation and transcription; and editing of all collected data; all attention was focused on data analysis, enabling a deeper consideration of data.

4.9.2 Simple quantification

This step was important as a response to my research aim to know if patients in Jordan have problems with postoperative pain. “Simple counts are sometimes used and may provide a useful summary of some aspects of the analysis.” (Pope, Ziebland, & Mays, 2000a). As well as “...an initial survey helps point the field-worker to phenomena of importance” (Miles & Huberman, 1994: 42). The failure of my hypothesis that patients have problems with pain would mean a change to the whole research topic. Therefore, NRS related questions were asked at the beginning of patients’ interviews to investigate pain prevalence and their severity in both hospitals (Chapter Three, Subsection 4.6.3)

This level of data processing was concerned mainly with descriptive analysis of the quantitative data that emerged from the interview questions

that included NRS. Such data addressed patients' pain severity and distress and were measured using a ruler. Frequencies and graphics are introduced to show pain prevalence in the two studied hospitals. Descriptive quantitative analysis was initiated using SPSS 17 after the fieldwork had finished, ensuring the inclusion of all necessary data in this analysis.

4.10 Reflexivity

Reflexivity in qualitative research has three main purposes, as is evident from the views of other researchers, and from my own fieldwork experience:

4.10.1 Scrutiny and rigour of the knowledge produced

The importance of the reflexivity 'process' when conducting any qualitative research is to expose oneself, collected data, and actions to self-scrutiny (Mason, 2002: 7). This is important since the presence of the researcher in the contexts of others has a bidirectional influence. While the researcher themselves may be influenced by the prevailing behaviours and values of the situation they are studying, their presence is also likely to influence that situation, (Denzin & Lincoln, 2005) since the researcher is part of the social world studied (Hammersley & Atkinson, 2007). Thus, it becomes important that the researcher takes steps back and reflects critically on the knowledge that has been produced, how it was generated, and how to confront and challenge assumptions in order to address potential bias or sources of influence (Guillemin & Gillam, 2004; Mason, 2002; Michalowski, 1996).

The researcher has many characteristics that might affect the conducted research in one way or another, such as sex, age, (Blaxter *et al.*, 2006), and even educational and professional background.

However, this does not mean that the researcher must remain detached from the field, which is neither easy nor desirable in qualitative research, unlike positivist research (Hammersley & Atkinson, 2007). Instead, it means that researchers must aim to create a balanced state through which they can penetrate the field, keeping minimal influence on participants' actions, behaviours and attitudes; while also remaining vigilant to, and recording the existence of, potential influences (Blaxter *et al.*, 2006). Such thick documentation of experiences and any effect on researcher's emotions will also enhance the trustworthiness of the research.

In the field, an appropriate balance was achieved by establishing a rapport with all participants, especially those with whom I met repeatedly, such as nurses, doctors, and long-stays patients and relatives. The rapport became deeper as my stay in the each hospital became longer.

However, the nature of the context in which I collected the data inevitably influenced me. Although I tried to maintain my identity as private, many people were curious to know who I was and to know personal information about my family life, and details about the research, including my expectation of what the findings might be. In such situations, I honestly answered that I did not have any idea about what the findings of the research would be, because the data collection and analysis had not yet been completed. However, in some cases, I talked about some aspects of my

personal life, such as my educational journey, just to keep the door open regarding some discussion with nurses and doctors.

On the other hand, reflexivity was embodied in changes I made to how I conducted the fieldwork. As Mason (2002: 7) writes, “qualitative researchers should make decisions on the basis not only of a sound research strategy, but also of a sensitivity to the changing contexts and situations in which the research takes place”. Examples of actions taken in response to needs in the field are summarised in Box (5).

Box 5: Actions taken in response to needs in the field

- “A change in the strategy of interviewing patients in this hospital (Public) should be made for the following reasons:
 1. The length of stay of surgical patients for most operations is less than 36 hours, which means that the discharging rate of patients is very high.
 2. Patients are discharged in the early morning, upon the doctors round which starts at 8:30 am-9:00 am.
 3. Many nursing and medicine students come at 8:00 am and the rooms become very crowded, and noisy.For the above reason, interviews will be scheduled with patients to be conducted in the early morning after their breakfast and before doctor's round. I will start interviews at 6:30 am since the majority of patients woke up at 5:00 am for blood tests and breakfast which is at 6:00 am, if patients agreed [Review planning summary: sheet number 19]”.
- A decision was made during the field work to complete interviews with staff nurses before beginning those with head nurses. This was to avoid the possibility that, if they knew the questions their staff were being asked, head nurses might interfere with the answers they provided.
- It was noticed during the observations that some shifts, such as shift (B) in the military hospital, and the beginning of shift (BC) in the public hospital were very rich with events since, at this time in the day, most patients' anaesthesia was diminished. But during the late shift (C), not many observations were recorded; hence, more focus was applied to shift (B), without ignoring the importance of shift (C).
- I selected two similar suits, of dark colours to wear for the fieldwork. It was like a uniform for me, in addition to the laboratory coat. This was to make sure my changing appearance did not attract the attention

of participants. Also, I thought that wearing similar clothes daily would decrease the attention participants paid to me personally.

Reflexivity as a process, rather than as a set of steps at a certain stage of any research, started when the preliminary literature review took place. During stages of literature review, I started recognizing that I focused more on the things I understand, and in other instances, I felt bored reading things that I did not understand, even though such literature might have carried different viewpoints: “knowledge screens the sound the third ear hears, so we hear only what we know” (Kurtz, 1989: 6). In such cases, I postponed reading study reports which I did not understand to a time when I felt better able to read slowly and to understand them more comprehensively.

4.10.2 Maintenance of ethical practice and principles throughout the research process

The purpose of reflexivity is not limited to developing an awareness of issues related to knowledge production, but also applies to any ethical issue that might emerge during fieldwork (Guillemin & Gillam, 2004). That is to keep ethical principles applied to practice as a continuous process rather than a cross sectional step that ends with the granting of access permission. Such considerations applied, for example, to changes made to the manner in which I obtained consent, modifications necessary to ensure that a climate of consent existed throughout observation episodes with changing patients and visitors (Chapter Three, Subsection 4.5).

In addition, and from an ethical perspective, after the first draft of some of the findings chapters had been written, a decision was made to omit the

participant's rank, and the date of both interviews and observations to avoid the possibility that they be identified. Such a decision had not been made before as it was not expected that the specific individual would be so easily identifiable from their rank.

4.10.3 Helps the researcher to identify their position from their own values, others' values, and from study findings

“Reflexivity entails a sensitivity to the researcher’s cultural, political, and social context. As such, ‘knowledge’ from a reflexive position is always a reflection of a researcher’s location in time and social space” (Bryman, 2008: 682). Thus, the researcher becomes more alert to their position as an outsider or insider in terms of their characteristics and background when facing or meeting people. Issues regarding positionality are further explored in the next section.

4.11 Positionality

In this section, two main issues are discussed:

- The researcher as insider-outsider in the field: How the researcher’s specific traits influenced her relations with interviewees, such as gender, professional background, motherhood experience, and nationality.
- How researcher’s experience influenced the way she looked at the research study, and its findings (methodological standpoints).

4.11.1 Insider and outsider

While conducting fieldwork, the researcher may be positioned as either an ‘insider’ or an ‘outsider’. Whether I saw myself, or was seen by others as an

outsider or an insider was influenced by many factors. Three particularly relevant factors related to my personal characteristics were:

- Professional background and educational level
- Gender, and
- Cultural background (native).

These three characteristics influenced access to participants, and data collection.

- **Professional background and educational level**

My professional background as a nurse played an important role in both the process of access and data collection. For example, I faced some challenges from the head of the IRB of the Governmental University, as well as from surgeons in both hospitals in the early stages of the study because I was a nurse. Some were surprised that nurses can do research in the field of a specialised topic such as pain. With all doctors, without any exception, I faced difficulties in convincing them to participate, and to talk in their own language. Using English was an important factor which allowed me to discuss issues with them on an equal level. I was keen not to show inferiority since this would hinder all of the effort made to maintain a symmetrical relationship between us. Doctors who agreed to participate in the research deliberately addressed me as ‘doctor’ in anticipation of my position as an academic nurse. Some doctors ignored my nursing background and talked to me about nurses negatively, forgetting that I was a nurse myself. Others tried to examine my knowledge through asking questions during morning rounds:

"I feel that doctors deliberately attempt to embarrass me while I am in the observation episodes ... Some of them ask me sudden questions in pathophysiology. Although I could answer their questions, I felt they wanted to embarrass me by asking questions that they expect I do not know the answers to. Although I did not want to reply because I am a researcher and I did not want to interrupt my role, I could not be silent any more, hence I answered two times just to show them that I have enough knowledge to answer questions" (Observation (3): My Notes (P. 35); S.F; M.H).

The situation was different with nurses who were encouraged by my professional background. Some of them were more willing to chat informally with me because I was a nurse. Some of them told me that if I was a physician, I would get less help:

"While sitting in the head nurse's office, one of the A.Ns ... asked me 'are you a doctor? I mean a training doctor?' I answered 'No, I am a nurse. I am a PhD student in nursing'. A S.N (Participant 21) said, 'She (referring to me) is from the same community [referring to nursing community]. Do you think I would be cooperative if she is from out of the community?' The A.N replied, 'Welcome, if you need any help, please just ask.' (Observation (3): F; S.F; M.H; Shift (c); 10:20pm)

I also used some expressions when I talked to nurses during informal or formal talk, like 'our', 'us' to reinforce rapport and to make them feel I am part of their nursing community:

"When I talked to nurses I used expression like: I, as a nurse; us. This was to make them trust me and to feel that I am not arrogant since the general view in Jordan is that academic nurses are superior to those in the field. I used these expressions also because some of the nurses have doubts, and suspect that I am a doctor or a social worker, not a nurse" Observation (1): My Notes (P.9); S.F; M.H).

Other nurses, especially in the military hospital, were proud that I was a nurse researcher and some of them said that it was encouraging to have a PhD researcher nurse given that doctors think that they know everything.

- **Nurse-researcher dual identity**

The dual role I occupied as nurse-researcher presented a challenge in the field, and echoes comments made by other researchers (see Krouse *et al.*, 2003). As Holloway and Wheeler have commented, “because their professional training guides them towards being carers and advocates for their clients, health professionals cannot close their eyes to distress and pain” (1995: 277).

However, over-involvement of the researcher in caring for patients might influence the collected data. This problem was partially tackled by introductory visits to both hospitals during which I clarified my role and responsibilities as a researcher in order to minimize any overestimation of my anticipated roles as a caregiver. This action was implemented together with continuous reflection after each fieldwork day:

“Actually, I wanted to intervene, but the nature of my mission and non-participant observation made this impossible except in cases of emergency. I prevented myself from helping many times when I heard patient’s screaming and shouting... However, I thought that I should not wait longer while staff did not take any action as I felt that waiting more would be immoral. Hence I just reminded the nurse that she said she would give him a painkiller after an hour and that hour has passed” (Observation (2): My Notes (P.6); S.M; M.H; Shift (B); 2:40pm)

On other occasions, I intervened slightly after I felt that I had collected enough data through observing without intervening as a professional. When I was asked about something by patients, I always referred them to nurses. I did not ask nurses to do anything since this would provoke a feeling that I am telling them what to do. In these cases, I kept away in order to observe what they would do in my absence.

Sometimes, I intervened when I saw that being silent would harm the patient. I thought that I had a moral responsibility to intervene because of my physical presence in that place:

“He was still asleep and under effect of anaesthesia when he tried to remove the drain tube from its place. So I acted on an individual basis for this patient and woke him since I knew that pulling out the drain tube might threaten the patient's operation and put him at risk of the surgery reopening or infection occurring. Intervening to rescue the patient from definite complications was my duty, especially with the presence of nobody in the room but me...”
[Observation (2): M; S.M; M.H; Shift (B); 3:45pm]

- **Gender**

“Gender is an important factor at all times and particularly within a socio-cultural context where gender segregation and patriarchy are commonly practiced,” (Al-Makhamreh & Lewando-Hundt, 2008: 11). For myself, my gender eased my access to participants, especially females, whether patients or staff, who felt they could express some of their experiences in their original language without the barriers I would have faced if I was male (Al-Makhamreh & Lewando-Hundt, 2008). My gender was important because I could conduct my observations in both female wards and male wards without being stopped.

The limited social acceptance of females talking with a stranger male was identified as one of the barriers to communication between staff and patients. This also impacted my role as a researcher in some instances, especially when I conducted some of my observations and interviews in male wards late at night. I felt embarrassed entering male patients' rooms during the late hours of observation nights:

"For me as a Jordanian female, at night time, it was embarrassing to enter rooms while they were asleep." (Observation (12); My Notes (P. 62); S.M; M.H; Shift (C); 4:05 am)

The feeling of being embarrassed became significant data. It stemmed from the feeling of being under *gaze* which has a role in how people learn how to act, or a role in discipline (Chapter Six, Section One, Subsection 1). Sometimes, I could not observe in rooms where some relatives criticised female nurses for watching male patients being assessed by doctors. Although I myself did not have deep concerns, I did not want other staff to see me as strange and over open to males. I did not feel it strange to talk and watch male patients' incisions being assessed by doctors because of my work experience. In the university hospital where I worked previously I used to do bathing for male patients in the cardiac surgery ICU. Thus, I think that I was sensitive to many issues in both the military and public hospital because of my different work experience. This made me an outsider for staff in both hospitals.

As a female I also felt greater acceptance from older nurses who knew me to be married, and especially those that knew I have a baby. However, the dual identity as a mother-researcher also created some challenges in the field, especially experiences in the rooms of adult patients where babies or very young patients were also admitted. Although paediatric patients have a separate ward in the hospital, some cases were admitted to adult male or female patient wards when the paediatric ward was full:

"I prevented myself from crying many times. As a mother, I could not see a child crying. This was another situation where I felt unable to separate my identity as a researcher, as a nurse, and more importantly as a mother. I thought that maybe my past personal

experience of losing a baby and separation from my daughter has impacted on my feelings. Actually, I could not enter the room again. I was afraid of failing to hide my tears and affecting how the nearby patients and relatives think of me.” (Observation (2): My Notes (P. 13); S.M; M.H; Shift (B); 3:05pm)

- **Being ‘native’**

Being a native Jordanian nurse researcher had unlimited benefits for me. A foreign researcher may have faced a number of challenges I avoided, especially when conducting research in a military hospital, where foreigners’ movements are always inspected.

Of further significance was that I could understand participants, especially patients and their relatives’ perspectives and the local language. My own background as a villager was also helpful as many participating patients were also from outside the major cities and I could understand expressions that some Jordanians, who were originally from urban areas, might not understand. Also, I could understand patients’ traditions and customs. For example, when relatives or patients presented sweets or chocolates to me, I accepted, since refusing them would build a big barrier against rapport and would show me as arrogant (Chapter Two, Subsection 5.5). However, in some cases, I refused the Arabic coffee that almost all patients had by their bedsides because they presented it in one cup that many people drank from. I refused because while I was conducting my research swine flu was at its peak, however, I explained my refusal to drink the coffee by saying that I do not drink coffee at all.

In addition, I used some kinship expressions (Al-Makhamreh & Lewando-Hundt, 2008) such as ‘uncle’ or ‘father’ to talk to older male patients and

relatives. Those expressions were used to build rapport and to show respect, since respecting older people in Jordan is a basic norm, especially among villagers and Bedouins (Chapter Two, Subsection 5.4). Also, I used ‘brother’ for male patients of the same age or younger than me, and some times addressed them as ‘Abu: Father of’. For female patients, I used ‘mother’ or ‘aunt’ or ‘Umm: mother of’ to show respect and build a positive relationship with older patients.

5. Methodological standpoints

One further point that needs to be acknowledged before proceeding to an introduction of findings is that this research was not aimed at attributing blame to any of the participants regarding aspects of their postoperative pain management. Rather, I have developed an inclination, at this stage of my progression as a researcher, to believe more in the ‘death of the author’, as Foucault outlined in his work regarding power and discourse. I realise that, in writing this, I am exposing myself to a strong wave of criticism from those who might feel that I am adopting a radical viewpoint against the freedom of individuals to make choices about the actions they take. However, building on my reading of Foucault, my theoretical perspective is that people are ‘vehicles’ of power influenced by multiple power relations, discourses, and contexts that construct their subjectivities and, accordingly, the emerging actions and perceptions: “The individual is an effect of power... The individual which power has constituted is at the same time its vehicle” (Foucault, 1980: 98).

Thus, a conviction developed in my mind that any individual, who might be placed within circumstances and contexts similar to those shown in the findings chapters, might develop similar actions and perceptions.

5.1 Reflecting on Foucault's insights with regards the research methodology and the chosen data collection methods

Both the choice of methodology and data collection methods showed the influence of the power of my position in relation to participants, although this was unintentional, and not a deliberate aim of this research. I believe that power practices can be found even in the research process. For example:

- The author argues that selecting the methodology of the research was an obvious exercise of power. This is because the researcher had planned intensively to use case study methodology, among other alternative methodologies, to enable an understanding and capturing of participants' perspectives and subjectivities (practices and attitudes). My standpoint saw actions as 'constructed' by different contexts, whether in the wider society, or in the organization of the hospital. Striving to penetrate human experiences is to attempt to reveal some hidden aspects of their lives and subjectivities, making them more vulnerable, and exposed. So, this striving to expose participants' perceptions and experiences is also a type of power practice.
- The exercise of power was extended further when the researcher selected data collection methods that could expose multiple perspectives

from multiple aspects. Observation, as a data collection method, is a practice of *gaze per se*.

Interview, as a data collection method, is an advanced movement towards a more professional *gaze* that reduces participants' experiences to a collection of written papers, and recorded words. Further, interviews transfer the *gaze* to a higher level. While *gaze* sees only observable signs, behaviours, and actions; interviews, like autopsies, may expose what is hidden: "an operation which, beyond first appearance, scrutinizes the body and discovers at the autopsy a visible invisible" (Foucault, 1975: 114).

- The third aspect of practising power appears through the way data was analysed. The researcher's reliance on the interpretative reading of data: interpreting participants' accounts, or in other words, their perspectives, is an exercise of power. As such the researcher will always reflect or view the experiences of others through his or her own experiences, life events, discourses, and convictions, despite efforts made to decrease such an effect. Interpreting the accounts of others through the lens of the researcher's own perspective is a practice of power because it allows the researcher to judge and label others, relying on their own interpretation of practices and attitudes.

Concluding remarks

This research has used a qualitative multiple case study design to study the factors that influence pain management in two hospitals in Jordan, one military and one public. Each hospital included two surgical departments

with male and female surgical wards. The study tried to grasp the issues related to pain management from different perspectives including those of: health care professionals, patients, and their relatives, in addition to persons in administrative positions. The data was collected using three main data collection methods: Non-participant observation supplemented by informal interviews, semi-structured interviews, and document review. The document review took place, at both hospitals, and in two universities: one governmental and one private, in order to verify any issues related to nursing education and clinical training.

Data analysis was conducted using a thematic approach. The findings of this thesis emerged through a deductive and inductive analysis of raw data. The next three chapters introduce these findings.

Is pain an issue among surgical patients?

Pain prevalence scores and observations

Introduction

This brief chapter introduces findings regarding pain prevalence drawn from a simple quantitative analysis of pain scores provided by different patients, and combines this with qualitative analysis of the pain incidents recorded through observations and interviews. This chapter also introduces findings related to the issues of utilizing pain scales among Jordanian surgical patients.

1. Issues related to utilizing NRS among Jordanian surgical patients

The interviewed patients (18 females, 20 males) were asked about the intensity of pain they experienced on the day of the operation, and on the day of the interview, whether it was the 1st, 2nd, or 3rd day postoperatively. The Numerical Rating Scale (NRS) was used to measure patients' pain severity, on which '10' expressed agonizing pain, and '0' indicated no pain at all. The same scale was used to assess pain distress: '0' indicating no distress, and '10' indicating very high distress.

Findings showed that about 42% (n=16/38) of interviewed patients could not give a discrete number to describe the severity of their pain. Instead, some patients ranked pain severity as more than ten. Assuming that the

bigger the number stated, the more severe the pain it indicated, such a result suggests that ten, or ‘agonizing’ was not considered a convincing representation of their experiences.

*“Patient: It was more than 10/10. It was an unimaginable pain.”
(P.T F(P-8); S.F; M.H)*

“Patient: More than 100/10. It was really distressful. I felt I was paralysed because I could not move at all because of the pain. I did not even have the desire to talk to anybody, including my sons.” P.T M(P-18); S.M; M.H)

“It is about million over ten, especially two to three hours after the operation. I could not do anything after operation. I could not move or sit upright.” (P.T M(P-16); S.M; M.H)

Some patients reported clearly their inability to give a specific discrete number to describe the severity of their pain:

“Patient: I cannot exactly describe its severity, but it was very severe.” (P.T M(P-10); S.M; M.H)

“Patient: It was really severe. I do not know how to describe it using a number, but maybe it was 8/10.” (P.T F(P-28); S.F; P.H)

Some patients gave a range or a period between two numbers on the pain scale when they could not describe the severity of the pain by a discrete number:

“Patient: I can put it on a point from five to ten.” (P.T F(P-2); S.F; M.H)

“Patient: Today it is less, but it is still severe. It is about 6-7/10. At least I can move although I have pain.” (P.T F(P-24); S.F; P.H)

Other patients, even after the scale was explained to them multiple times, thought that ‘0’ indicated agonizing pain, and ‘10’ indicated no pain:

“Researcher: How severe was the sensation of pain postoperatively? If I told you that this ruler is divided from zero to

ten, zero means no pain at all, and ten means agonizing pain. Where do you point to describe your pain status?

Patient: About 7/10..., but I could tolerate it.

Researcher: On the same ruler, how severe is the sensation of pain today?

Patient: Today it is 9/10. It is less pain than yesterday. It is localized around the incision." (P.T F(P-22); S.F; P.H)

Table (7) shows the percentage of patients who were able to rank pain severity and distress, and the number of those who could not at different days postoperatively.

Table (7): Number and percentage of patients who could/could not rank pain and distress severity						
Day of interview	Severity of the pain			Pain distress		
	Patients could score pain	Patients could not score pain	Total	Patients could score distress	Patients could not score distress	Total
Zero	22 (58%)	16 (42%)	38	2 (5%)	36 (95%)	38 (100%)
1st	19 (70%)	8 (30%)	27			
2nd & 3rd	6 (55%)	5 (45%)	11			
1st, 2nd, 3rd.	25 (66%)	13 (34%)	38			

It is worth mentioning that patients who could not score the severity of their pain are of both genders. The findings in Table (7) are clinically important because they show that NRS was ineffective at rating pain severity for a large percentage of patients postoperatively, as well as that the majority of patients (95%) were unable to rate pain distress.

These findings brought to the surface questions regarding the efficacy of using the NRS to assess patient pain in Jordanian hospitals without taking into account factors which may influence patients' willingness to reveal pain scores. The rate of pain prevalence reported may be under-representative of

the true situation due to either the unfamiliarity of patients with the scale itself, or because shyness or stoic beliefs hinder their willingness to report pain to others of a different gender, or in the presence of others (Chapter Six, Section One, Subsection 3).

The analysis of the prevalence of postoperative pain intensity has been carried out using SPSS 17, focusing on the cases where those questioned could score the severity of pain, and considering those that could not as 'missing cases'.

2. Pain prevalence among patients who could score their pain

Among patients who could score the severity of pain that they experienced on the day of operation postoperatively (n=22), the median of the pain score was about 8/10. Few patients experienced low scores of pain severity (3 and 4 on NRS), and a majority (90%) experienced pain of scores from 5/10 to 10/10 (Figure 4).

Figure (4): Frequency of pain scores among patients at day zero postoperatively

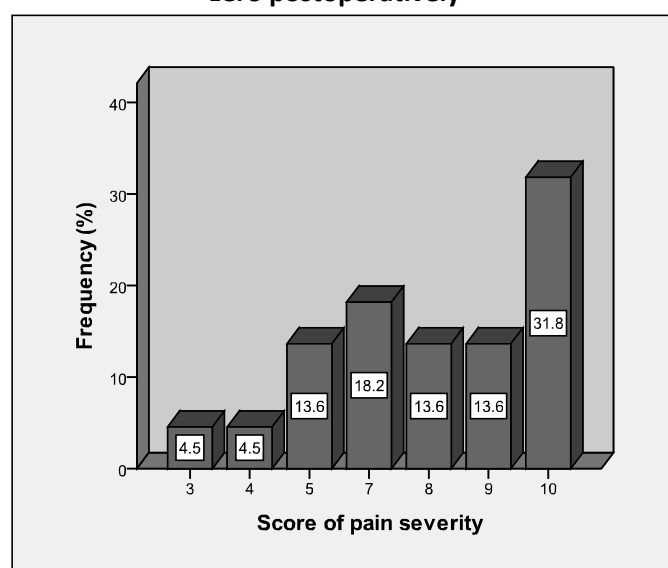


Table (8) also shows that 74% (n= 14) of patients, who were interviewed on the first day postoperatively, experienced pain intensity of 5/10 or more, with a median of 5, and only 26% (n=5) experienced pain of severity less than 5/10.

Table (8): Frequency of pain scores at time of interviews (1st, 2nd, 3rd day postoperatively)									
Day	pain score at time of interview								
	3	4	5	6	7	8	9	10	Total
1 st	3 (15.8%)	2 (10.5%)	7 (36.8%)	3 (15.8%)	0	1 (5.3%)	1 (5.3%)	2 (10.5%)	19 (100%)
2 nd	0	1 (33.3%)	1 (33.3%)	0	1 (33.3%)	0	0	0	3 (100%)
3 rd	1 (33.3%)	0	0	0	2 (66.7%)	0	0	0	3 (100%)

Although the number of patients who could score their pain is relatively small on each day, the information gives at least an indication about the prevalence of pain in the examined wards during the first day postoperatively. The findings show that the majority of patients experienced pain intensity of 5 or more on NRS during the day of operation (90%), and during the first day post operation (74%).

Furthermore, correlation of this data with information about pain incidents that was collected through observations and interviews with patients and their relatives shows that all of the patients who said that they could not score their pain had experienced intense pain. Pain incidents were found very frequently in both observations and interviews, and the following examples provide some indication of how they were spoken of by patients and relatives:

"After a while, she became conscious, and said that she had pain at the location of the operation wound. Even at night, she could not sleep at all... After the operation, she kept twisting and turning in the bed until 10:00 am the next day, when the doctor assessed her wound and allowed her to eat and drink, since she was fasting" (F.Relative(P.T F(P-6); S.F; M.H)

"I entered the room of a patient who I already knew had undergone an operation to repair an anal fissure. I found him awake. I said, "your nearby patients are asleep, you are the only one who still awake!?" He replied, "I have pain". (Observation (9); M; S.M; P.H; Shift (C); 12:50am)

Patients screaming and crying in pain were observed on a daily basis during observations and at different times of interviews, even on the third day after their operations:

"I was walking in the corridor when I heard a patient moaning. I followed the origin of the voice to a patients' room of four beds. It is a female patient, 22yrs old, 3rd day post appendectomy." Observation (1): S.F; P.H; Shift (A); 8:05 am)

"In a room of two beds, a patient (62years, two hours post hysterectomy) is crying, moaning 'Oooh, Allah, I have severe pain'." (Observation (10); F; S.F; M.H; Shift (A); 12:10 pm)

"Room(X), a patient (post Haemorrhoidectomy, 28 years old) has returned from the operation theatre five minutes ago. Patient is screaming and shouting 'Ahhh.. Allah...Allah... please help me...father..I am dying...please doctors...where are doctors?'. Observation (2); M; S.M; M.H; Shift (B); 2:30pm)

"I kept returning to this patient's room in order to see how his pain is progressing. The patient is lying in the bed, in a closed position, sweaty, and is complaining of pain. Once I entered the room, he begged me to bring him a painkiller." (Observation (7): S.M; P.H; Shift (A); 2:30 pm)

Both informal and semi-structured interviews suggested that under-managed pain causes serious health complications, as some doctors said:

"Some operations induce more pain than others. For example, Laparotomy or any surgery that involves an upper abdominal incision induces a very severe pain. If the patient after one of those

operations is not given a painkiller regularly, this will impact his respiration, and breath, because the patient will start to breathe shallowly to decrease pain induced by deep breathing” (D.R 69; M; P.H)

“After thoracic surgeries, I think that the priority is to encourage the patient to breathe deeply to prevent atelectasis. Hence, it is important to save him from the feeling of pain on breathing by giving him morphine injections... Personally, I treat patients taking into account the patient’s medical case and severity of pain. For example, I prescribe a strong painkiller for patients with burns, since the priority in burning cases is to treat pain first. Some burning patients might die because of pain.” (D.R 71; M; P.H)

“The immobility of the patient because of pain postoperatively causes blood stasis in lower limbs leading to deep vein thrombosis, which might shatter and cause pulmonary embolism...” (D.R 34; M; M.H)

Some patients spoke about experiencing breathing difficulties because of the pain they experienced postoperatively:

“I was extremely distressed and unable to breathe because of pain. I kept breathing shallowly in order to avoid feeling of further pain. I also kept twisting in the bed until I was given the painkiller injection.”(P.T F(P-3); S.F; M.H)

“It is very distressing. It caused me a shortness of breath. I was afraid of taking a deep breath or yawning since it caused a severe pain. I would like to walk and leave this bed, but I cannot. I feel I am a prisoner in this bed...”(P.T F(P-6); S.F; M.H)

“I could not breathe easily, and I had severe back pain. The pain worsened each time I took a deep breath. I had a shallow breath with a lot of sputum when I coughed. Coughing also increased my pain.” (P.T F(P-29); S.F; P.H)

Other patients reported complications such as elevated blood pressure and loss of appetite:

“My mouth became dry because of continuous screaming and begging. Because of the continuous pain, my blood pressure elevated. I even ... had no appetite for eating anything” (P.T F(P-1);

S.F; M.H)

Others said that pain impacted their activities and movement:

"I am extremely distressed because of the pain I had yesterday and of the pain I feel today. It impedes my movement. It impedes walking, and moving independently. Yesterday, I stayed immobile for a long time because the pain increased with movement." (P.T F(P-4); S.F; M.H)

"After I was discharged from the operation, I was afraid of moving my leg... I am distressed because I am afraid of moving it. I do not want to experience the same pain I have experienced before the operation... Doctors told me to walk, but I did not do this until now." (P.T F(P-7); S.F; M.H)

"The pain was distressing and annoying. I avoided moving frequently, or coughing because they both increased pain." (P.T M(P-31); S.M; P.H)

Some patients reported experiencing sleep pattern disturbances:

"She did not sleep at all the night after the operation. During sleeping, she keeps moaning and saying, 'call nurses, I feel pain over all my body'." (F.Relative (4); S.F; M.H)

"I cannot ignore how severe it was. I did not sleep all night because of it." (P.T F(P-14); S.F; M.H)

Some complications specific to the site of the surgery were also reported.

For example, operations including the anus caused immobility and constipation because of fear of defecation, as some patients reported:

"I do not dare to defecate at all because of the pain. This makes additional troubles and discomfort. I nearly do not dare to sit upright" (P.T M(P-12); Haemorrhoidectomy); S.M; M.H)

"Because of the severe pain I felt, I could not go to the bathroom, and I could not even sit upright. I've slept on my abdomen all the time since the day of operation..." (P.T M(P-5); Perineal abscess); S.M; M.H)

"I am very distressed. I am afraid to defecate. I am afraid that the operation will be spoiled if I defecate. I have not even urinated since yesterday. I went to the bathroom multiple times, but I am afraid." (P.T M(P-33): Haemorrhoidectomy); S.M; P.H)

These patient reports about the consequences of untreated pain clearly display 'fears' of pain complications by both female and male patients in both hospitals. Such fears may operate as a potential, but serious, obstacle to recovery.

In the hospitals studied, patients experienced severe pain not only postoperatively, but also before they underwent operations. For example, some patients reported preoperative pain as having been ignored with serious consequences:

"I started shouting and cursing the hospital because nobody appreciated my pain. The multiple postponing of my operation caused the appendix to rupture..." (P.T M(P-35): S.M; P.H)

"The doctor did not acknowledge the pain I had. The result was that I had a ruptured appendicitis..." Observation (13): M; S.M; P.H; Shift (A); 11:00 am)

"I kept shouting in pain until 1:00 am at night, but nobody responded. At 1:00 am I fell unconscious. When I woke up at the evening of the next day, I knew that the infected appendix had ruptured, and doctors performed the operation to me." (P.T M(P-15): S.M; M.H)

Concluding remarks

The pain incidents in the collected data show that patients in two Jordanian hospitals experience postoperative pain of relatively high severity on the day of operation and first day postoperatively. Measuring pain severity and associated distress by NRS seemed to be difficult, opening up room for further research to study the surrounding contexts and variables when

measuring pain intensity using any of the pain scales in Jordanian hospitals. There was evidence that ineffectively managed pain, experienced preoperatively or postoperatively, can lead to physiological and emotional complications.

The following two chapters introduce findings regarding factors that influence pain management and its outcomes. The next chapter presents findings related to the effect of people's relationships on practices in pain management and consequently their effect on pain management outcomes.

Section One

Nurse-doctor relations

Introduction

This section introduces findings related to the nurse-doctor relations, and to its influence on the practices of both professionals with particular reference to pain management. This section uses Foucault's theoretical concepts to connect the empirical findings to the underpinning theory.

1. Lack of nurse-doctor discussion about postoperative pain

Findings showed that nurses and doctors meet primarily during the morning ward rounds and for short periods. The observations conducted during ward rounds, and the interviews with both nurses and doctors, revealed an apparent lack of nurse-doctor discussion regarding patients' care in general, and pain specifically:

"We do not participate in making decisions regarding pain, or other things regarding patient care. We only apply doctors' orders...Postoperatively, doctors' orders of painkillers are written on the patients' medical file in the operation theatre, and then they are sent with the patient. Thus, we do not discuss with them how the care regarding pain will be achieved." (S.N P(17); F; S.F; M.H)

"We do not discuss with doctors the decisions they make. We mostly meet during the doctors' round. The role of nurses during the doctors' round is to inform doctors about the patients' cases, and to apply their orders,"(S.N P(6); F; S.M; M.H)

"A Staff nurse (female) accompanied doctors during their round. The nurse carried patients' medical files. No discussion took place between the nurse and doctors during the round..." (Observation (11): S.M; P.H; Shift (A); 8:15am).

Nurses and doctors attributed the lack of discussion to different causes, and in many instances, each blamed the other for the lack of discussion. Nurses, for example, attributed lack of discussion to doctors' practice of power over them. They explained variously that:

- Doctors like to show authority, and to protect or "monopolize" the right to make decisions. Thus, they exclude nurses from the decision making process, as nurses in both hospitals said:

"There are some doctors who like to show their power and authority over nurses in front of patients. Doctors everywhere in Jordan consider making decisions their own right, hence they protect it. Without this right, they are weak." (S.N P(3); F; S.M; M.H)

"My relationship with doctors is good. However doctors do not give us any opportunity to make suggestions regarding patients' care. This is not because we are unknowledgeable, but because the doctors try to protect their right to make decisions." (S.N P(53); F; S.M; P.H)

- Doctors viewed nurses as 'inferior'. Thus, nurses avoided making suggestions:

"The problem is that doctors do not want nurses to deal with them on an equal basis. Doctors act with superiority and contempt. I once heard a doctor say to a nurse who suggested something, 'who is the doctor here, me or you?'" (S.N P(6); F; S.M; M.H)

"..If any nurse suggests something, the doctor might say, 'who are you to say this in my presence?' Personally, I avoid becoming involved in these situations. Doctors make us feel that they have a higher status than we have." (S.N P(54); F; S.F; P.H)

- Nurses also mentioned doctors' tense mood or abrupt responses as an influential factor on their unwillingness to discuss matters with them:

"My relationship with specialists is formal and shallow. I only apply their orders. We do not discuss with specialists, because some of them are nervous and the rest of them are 'tough' in dealing with nurses..." (S.N P(54); F; S.F; P.H)

"Usually, we do not get involved in discussion with doctors. Our ability to discuss a patient's condition relies on the doctor's mood." (S.N P(3); F; S.M; M.H)

"When I accompany a doctor during the round, I might make suggestions if the doctor is a kind and a friendly person, and avoid doing this with doctors who I do not know..." (S.N P(21); F; S.F; M.H)

- Finally, some nurses mentioned the conflicts that occur with doctors regarding nurses making direct or indirect suggestions, and the need to avoid them:

"In general, many conflicts have occurred between me and doctors, even when I made indirect suggestions. Some doctors reply with mockery, 'do you want to continue this round instead of me?'. This response was enough for me to stop discussing with this doctor until the end of my life because I do not want to be embarrassed in front of patients, nurses of lower ranks, and medical students." (S.N P(3); F; S.M; M.H)

There was, however, something of a split between nursing staff regarding the effect of the different knowledge of doctors and nurses. Some, especially those of long expertise, reported that they did not feel that nurses' lack of knowledge caused conflict or discouraged them to discuss pain management issues with doctors. As the head of the surgical department said:

"Some doctors claim that nurses have a lack of nursing knowledge although I think that my nurses are knowledgeable. However, doctors view nurses as inferior. This view will never change as long as nurses and doctors work together. I think that the lack of knowledge is not the real reason nurses feel discouraged from making suggestions; it is the hierarchical nature of the relationship between doctors and nurses. Thus, I think that nurses do not have enough courage to make decisions without calling a doctor." (H.N P(1); F; S.M; M.H)

Other nurses blamed themselves regarding the lack of knowledge as well as low self-esteem as reasons for their inability to discuss issues with doctors:

"Yes, challenges arise between staff nurses and doctors when nurses make any suggestion, whether it is regarding pain or anything else. However, I think that conflicts arise because of nurses' low self-esteem and lack of knowledge." (S.N P(14); M; S.M; M.H)

"I did not fall into conflict with any of the doctors. However, other nurses were ignored when they suggested doing something for some patients. I think that the influential factor is the strength of the nurse's personality and knowledge. I believe that the stronger the nurse's personality and knowledge are, the less the nurse will be ignored by doctors." (S.N P(57); M; S.M; P.H)

Doctors, in turn, blamed nurses for the lack of discussion when they worked together, and some reported that nurses did not participate in making suggestions because of their lack of nursing knowledge:

"No, we do not. I can rationalize this by the lack of nurses' knowledge of their rights and duties. They have also a lack of nursing knowledge..." (D.R (36); M; M.H)

"In fact, I like nurses to make suggestions and participate in making decisions about patient care. However, nurses do not make any effort to make any suggestions based on knowledge..." (D.R (44); M; M.H)

"...Our nurses are not clever enough..." (D.R (39); M; M.H)

Furthermore, doctors had set jurisdictional boundaries and talked about this issue. Some doctors confirmed that they consider making decisions regarding patients' pain as part of their professional status. They considered that any suggestion from nurses interfered with this boundary:

"I consider any suggestion or order made by nurses as interference with my duties and business. Maybe, if they make a suggestion in a friendly way, I might think seriously about it. However, I do not accept any suggestion made by a nurse in a serious fashion..." (D.R (39); M; M.H)

"Of course No. I only tell nurses how to apply my orders. Nurses should not write orders or suggest orders because, I suppose, the doctor is more knowledgeable and more informed about the patients' conditions. I am not talking about superiority here..." (D.R (71); M; P.H)

Some doctors felt that allowing discussion with nurses would encourage a friendly relationship rather than a professional working relationship, and that this might make nurses careless regarding their orders. Thus, they blocked communication to appear serious or strict:

"I have a good relationship with nurses regardless their gender. But I am serious in my work, and I do not forgive any nurse if their carelessness causes harm or prolongs patients' suffering. I used to deal seriously with nurses because they spoil if I am friendly with them. Nurses should fear me, in order to apply my orders and not ignore them." (D.R (36); M; M.H)

The hierarchical system, especially in the military hospital, as represented by rank, was identified by doctors as another cause of the lack of discussion between doctors and nurses:

"We have not reached this developed stage when a nurse discusses with doctors and participates in making decisions regarding the care provided to patients. Maybe, this is not applicable in military hospitals since the nurses fear discussion with persons of higher rank." (D.R (33); M; M.H)

However, even when a nurse held higher military rank than a doctor, they rarely made suggestions. It was apparent that the relationship between nurses and doctors in both hospitals was, without exception, built on a base of professional status rather than rank or years of experience. Among nurses in the military hospital, rank did not add any further power to their professional status in relation to doctors:

"...I am the only nurse in the ward who can discuss with doctors freely. As I said before, this is not because I am a nurse of a high rank, but because I am a head nurse. Doctors deal with me as a head nurse or as an administrator, ignoring my nursing background." (H.N P(1): High rank; F; S.M; M.H)

"No, the rank of the nurse does not support a nurse's position in front of doctors. The main influential factor is the doctor's

personality and his ideas about nurses. There are some doctors who like to show their power and authority over nurses of any rank in front of patients...I think that the influence of the professional status is stronger than the rank in determining how professionals deal with each other. Almost always, we do not deal with each other on the basis of rank, but as a doctor, who owns the superiority and authority and power, and a nurse, who is the applier of a doctor's orders. I can prove this; I am a captain nurse; when I enter a room, any room, doctors of lower rank do not stand up for me. However, when a doctor of a higher rank enters the room, all nurses, including the head nurse stand up for him... in addition, when a doctor of a high rank orders something, I say 'OK, Sir', but when a nurse of a high rank suggests something, doctors may ignore her suggestions." (S.N P(3); F; S.M; M.H)

"Our relationship with doctors is governed mostly by their professional status, not by our rank." (S.N P(6); F; S.M; M.H)

So, the interviews conducted with nurses and doctors indicate that, in both studied hospitals, the nurse-doctor relation is a type of hierarchical relationship.

This hierarchy was also displayed in doctors' marginalization of the nurses' role in pain management. Marginalization appeared clearly even in the language doctors used when they talked about the potential role of nurses in pain management:

*"No, no discussion regarding patients' cases happens between nurses and doctors... Simply, I write the painkiller order after finishing the operation of a patient, and when he is discharged to the ward nurses become responsible for applying my orders... I think that pain management should be the responsibility of a medical team. The anaesthetist should check patients the night before the operation...The team that I mean is composed of the surgeon, anaesthetist, and **even** nurses in the recovery room and in departments."* (D.R (43); M; M.H)

The use of the language above, such as '*even nurses*' seems to indicate that doctors do not totally believe in the importance of nurses' participation in

pain management, and this might be another reason for their limited involvement.

Other doctors said that the nurses' job within the anticipated pain team is limited to informing doctors about patients' pain:

"Pain management is a team responsibility. I think that the anaesthetists should be the first member in the team. He should become acquainted with patients before the time of their operations, and should be responsible for patients' pain management until the end of the operation, and even immediately after the operation. The surgeon is another member in the team, since it is he that is responsible for the patient's entire health condition until they are discharged from the hospital. Nurses and pharmacists also have a role in pain management. I stress that the one who should provide information about pain is the nurse." (D.R P(37); M; M.H)

The marginalization of nurses from patients' pain management was shown not only by ignoring their role, but was displayed in the spatial behaviour of nurses. Spatial marginalization was overt simply by observing the physical place of nurses during the doctors' ward rounds. Nurses, in all observations that were conducted in both hospitals, were standing behind doctors and medical students, and entered rooms last. None of the observation notes show that nurses took a significant spatial place in any discussion or rounds with doctors:

"One of the staff nurses has accompanied doctors in their morning rounds. The nurse carried patients' medical files. No discussion took place between the nurse and the doctors during the round. The nurse entered patients' rooms at the end, behind doctors. The senior doctor directed questions regarding patients' case progress to the resident doctors, but not to the accompanying nurse." (Observation (11): S.M; P.H; Shift (A); 8:30am)

"In a room of two beds, the doctor (P. 39)... exposed the abdomen of the patients (1st day post hysterectomy). The nurses were standing behind the medicine students carrying patients' files, ... Nurses only

read laboratory test results, and medications orders when the doctors asked them to do so.” (Observation (9): S.F; M.H; Shift (A); 9:25 am)

Conducting observations during doctors’ ward rounds also shed light on the tasks that nurses carried out during the presence of doctors. It was noticed that when involved in direct contact with doctors, nurses: a). did only what doctors asked them to do:

“In a room of two beds, the doctor (P.39) ordered the S.N (P.17) to close the door of the patient’s room after he entered. Then he asked her to hand him the drainage bottle which was on the ground.” (Observation (9): S.F; M.H; Shift (A); 8: 55am)

b). Carried out ‘dirty jobs’:

“In a room of four beds, the doctor is assessing a patient with severe constipation. The doctor asked the nurse for gloves to assess the internal ring of the anus...the S.N (P.3) closed the blinds and stayed outside the curtain. When the doctor finished, he opened the curtains and handed the dirty glove to the nurse saying, ‘throw it in the medical waste bin’” (Observation (10): S.M; M.H; Shift (A); 9:35am)

c). Or carried out tasks that did not involve showing any knowledge or expertise:

“... Lieutenant/1 doctor (P.34) speaking to the nurse said, ‘remove the dressing from the foot’. The S.N (P.3: Captain) ‘OK, Sir’. After finishing assessing the wound, the doctor asked the nurse to return the dressing as it was...” (Observation (1): S.M; M.H; Shift (A); 8:30am)

“The main communication time slot between nurses and doctors is the doctors’ morning round. During doctors’ rounds, our role is limited to informing doctors regarding patients’ lab tests results and the amount of fluid excreted in the drainage bottles, if any. We also record the new doctors’ orders for each patient.” (S.N P(22): F; S.F; M.H)

When it came to the discussion and knowledge about patients’ pain or care, doctors directed questions and provoked discussion with other

accompanying doctors, who were mostly resident doctors or doctors of lower rank, but not with nurses:

"S.N (P.65) accompanied doctors on their rounds. She carried the patients' medical files, and guided doctors to the rooms of patients. During the round, no discussion of any type took place between doctors and the nurse. The specialist doctor asked the resident doctor about the progress of patients' cases." (Observation (1): S.F; P.H; Shift (A): 8:55am)

From this, it seems that marginalization is a significant reason for the dominance of doctors over nurses. Three types of marginalization have been identified: knowledge marginalization; spatial marginalization; and skill marginalization.

When analysing their domination and marginalization by doctors, nurses' responses shown to be varied from being 'disciplined', in that they *interiorized* the conflicts and learned their role boundaries, but expressed being unsatisfied; to others fulfilling these inferior views by obeying without questioning and acting as 'docile'; and, finally, some nurses reported actions of 'resistance', expressing refusal of being marginalized.

2. Nurses in the position of being 'disciplined' and/or 'docile'

The review of documents in both hospitals revealed that there are brief job descriptions that describe the role of nurses of different grades, but no official document was found which describes the roles of nurses and doctors. This observation provoked the question of how nurses learn about their roles in pain management in Jordanian hospitals. One potential answer was university education. However, the document review of nursing syllabuses in both universities showed that nurses learn about pain for less

than 30 minutes during the whole four years of study, and there is a severe lack of information regarding nurses' role in pain management within multidisciplinary teams. Thus, and as interviews revealed, interacting with other professionals during daily work life seemed to be the primary way through which nurses learned their roles and boundaries. In other words, examples of nurses being disciplined through interacting with others were captured.

Doctors' responses to nurses' suggestions or attempts to make suggestions clearly embodied attempts at enforcing discipline through berating and marginalization:

"Because I spend more time with patients, I would like to make suggestions regarding their progress. However, the doctors' view of nurses prevents me from doing this. I feel I am being marginalized each time I talk with doctors. I see in their eyes that they say, 'you are nothing. What do you know about my work?' Thus, I keep silent all the time in the presence of doctors. If they ask, I answer. Just that." (S.N P(24); F; S.F; M.H)

"We do not discuss anything with doctor. We might draw their attention to something. Personally I avoid embarrassing myself with doctors by making a suggestion upon which I might be berated, or will definitely be ignored." (S.N P(63); F; S.F; P.H)

The continuous exposure to doctors' disciplinary power seems to have made some nurses more obedient, or docile. Nursing docility appears in many nurses' practices, such as referring to doctors in all matters whatever the significance of the situation; applying doctors' orders without questioning, and not referring to other nurses' knowledge or expertise for help before calling doctors:

"Researcher: *What happens if a patient is in severe pain while the doctor is unavailable for any reason?*

S.N: I call him by telephone, and ask him what should I do. If he does not answer, I keep calling him.” (S.N P(21); F; S.F; M.H)

“When nurses came and measured my temperature, I told them that I have severe pain, but they said, ‘wait for the doctor. He will come within a few hours. I do not know what he will order for you’. Until the present moment, I have severe pain, and neither has the doctor come, nor have the nurses given me anything to decrease my pain.”(P.T F(P-23): S.F; P.H)

“Patient’s son: ‘When my father complained of severe pain, the nurses did not dare to give him a painkiller. They only waited for the doctor’s order... I want to say that nurses here, like machinery, are acting according to what is written on paper, not according to the patient’s condition or the progress of his case condition.” (M.Relative (P.T M(P-11); S.M; M.H)

The nurses’ docility also seems to be reflected negatively in their self-development and learning, and in their settling for orders given by doctors:

“I do not think that I need any further information regarding pain management since pain can be simply relieved by a doctor’s order of a painkiller.” (S.N P(11);F; S.M; M.H)

The hierarchical nurse-doctor relations based on marginalization/domination hindered effective management of patients’ pain by prolonging the time the patient had to wait in pain without action by nurses who preferred to wait for guidance from doctors.

This hierarchical relationship also hindered pain management outcomes by reinforcing missing patients’ pain complaints and interfering with the communication of these complaints between doctors and nurses. This happened because nurses did not make suggestions or discuss patients’ pain complaints or other affairs with doctors because of interiorizing marginalization and inferiority. This was also a result of fear felt by nurses about provoking conflicts with doctors:

"Some doctors might not fully listen to nurses' suggestions, or do not take them seriously, although the suggestion might derive from a patient's complaint during the shift. Thus, the patients' complaint goes into the air." (S.N P(6); F; S.M; M.H)

"The patient called the nurse and told her to tell the doctor that his operation was hurting him because of his flatulence saying, 'would you inform the doctor that I have pain on the incision because of flatulence?'. The S.N replied, 'If he is calm, I will tell him...' (Observation (1):S.M; M.H; Shift (A); 9:45am)

The problem of failing to pass on patients' pain complaints was not only overt in the communication between nurses and doctors, but also between members of the nursing team themselves in both hospitals. There are many examples in the collected data which show that patients' complaints were not communicated between nursing team members on different shifts. Findings regarding the content of the discussions that took place in nursing rounds between different shifts showed that patients' complaints of pain were not passed from one shift to the next shift:

"The main problem here is the nature of the nurses' shift work, since nurses do not communicate patients' pain complaints. They only talk about procedures done to the patients, results of lab tests, and medications. In other words, if there was a patient at midnight complaining of severe pain, nurses will not talk about this patient's complaint together at the nursing morning round. Hence, patients' complaints will fail to be passed from a shift to a shift, and will be lost." (D.R (41); M; M.H)

"I accompanied the nurses in their round. The nursing round was finished within six minutes. The S.N of the finished shift (A) informed the S.N of the starting shift (BC) about patients' names, cases, and if they will undergo operations the next day or not." (Observation (8): S.M; P.H; Shift (B); 2:55pm)

The reader might question whether nurses or doctors communicated messages regarding patients' pain by documenting them on patients'

profiles. However, the document review of patients' medical profiles, with emphasis on nursing and doctors' notes, showed that neither doctors, nor nurses in both hospitals regularly documented patients' pain complaints. Nurses in the military hospital only documented the Pethidine injections or narcotics given on a separate prescription sheet, and this sheet was placed in the narcotics locker. Thus, only the staff nurse in charge, who had the keys to the locker, could see these prescriptions. The same thing, with a relatively small difference, happened in the public hospital. In addition to documenting it on the prescription sheet and narcotic locker notebook, nurses in the public hospital documented the narcotics injections given to patients on nursing note sheets, with no other additions. These notes did not give any indication about patients' pain severity, or characteristics; and because there was an absence of re-assessment skills, as will be shown in the following section, the documented notes did not give any indication about the response of patient to the given painkiller.

3. Nurses in position of resistance to domination-marginalization by doctors

Because "there are always also movements in the opposite directions..." (Foucault, 1980: 199), resistance is an expected consequence of the domination/marginalization relationship. Thus, in challenging different types of marginalization by doctors, some nurses had developed techniques of resistance. These techniques had an indirect and maybe unintentional impact on the pain management process. For example, some nurses often did not apply doctors' orders literally as they were written. Instead, they

relied on their own convictions and evaluation. As one nurse said, they tried to play a role in managing pain by modifying the application of doctors' orders of painkillers. This appears in the way nurses applied doctor's 'regular' orders according to their beliefs and knowledge:

"Actually, I adhere to the dose in the doctor's order because the doctor prescribes medications relying on the patient's weight. However, I have a role in the way I implement the order. For example, I do not apply all 'regular' orders literally. I apply them as PRN orders, even if the doctor wrote 'regularly'. I apply regular orders literally only in cases of major and serious operations, such as laparotomy because of its big wound size and length, and sensitive site." (S.N P(57); M; S.M; P.H)

"I left the patient's room, and then reviewed the patient's medical profile. The post operation doctor's order was, 'Pethidine 75 mg Q 6hrs I.M'. I asked the S.N (P-57) about the way they interpret this type of orders. He said, 'I always consider this type of order as a PRN order not a regular order, even if the doctors wrote 'regular'. I refuse that... I always administer Pethidine on a PRN basis. I think that Pethidine should only be given after a major and a serious operation, such as abdominal laparotomy. However, other surgeries, such as appendectomy, herniotomy, or even cholecystectomy, do not cause severe pain, hence Pethidine should be given only PRN'." (Observation (10); S.M; P.H; Shift (B); 6:00pm)

Nurses' resistance using this technique was apparent not only through interviews, this behaviour was noted by doctors who talked to patients and relatives:

"I was standing in front of the nursing counter when a doctor who I talked to before regarding my research came and started chatting with me, saying, '... usually, we order regular doses of painkillers, mostly Pethidine, postoperatively for all patients. However, I am always surprised when patients tell me that they were not given their painkiller regularly postoperatively. Some of them say that they were not given their prescribed painkillers at all..." (Observation (4); S.F; P.H; Shift (B); 5:45pm)

The document review of patients' medical profiles also provided evidence that doctors' orders were not applied literally by nurses:

"Reviewing this patient's medical profile: the doctor's post operation order was: 'Pethidine, 75 mg, I.M, Q6 hrs'...The medication sheet and the nursing notes showed that the patient was given only two doses of Pethidine in the first 24 hours post operation; the first dose was administered one hour after the operation, and the second was 12 hours post operation." (Observation (3): Document review; Patient profile; S.F; P.H; Shift (C); 10:15pm)

Such action could prolong patients' suffering of pain:

"I had very severe pain. I asked nurses for a painkiller. They gave me a painkiller injection nearly 30 minutes after the operation. I slept about 3-4 hours, and when I woke up at nearly three in the afternoon the pain was severe. I asked them to give me another painkiller injection, but the nurses refused. Although they told me that I will be given a painkiller injection every six hours, they gave me only two injections after the operation. The second injection was given to me at 10:00pm." (P.T M(P-33); S.M; P.H)

So, it is apparent that this compound of marginalization-resistance in the nurse-doctor relations had a negative effect on patients' pain management. Thus, this is a chance to revise the hierarchical power relations produced by marginalization-resistance, and suggest instead a collaborative relationship based on communication and teamwork.

A multidisciplinary collaborative relationship would enable each party to reveal their beliefs and knowledge, and participate in the decision making process. A collaborative relationship is based on the necessity that one part listens to the other parts' (doctors to nurses) suggestions. If doctors refuse nurses' suggestions, they might need to explain to nurses why it is that things should be done differently to how they suggest. In other words, two-way discussion is needed, where nurses listen to doctors and doctors listen to nurses.

However, if the relationship continues to be hierarchical, and doctors continue to impose their knowledge and orders, marginalizing the role of nurses, nurses might continue to impose part of their convictions and knowledge in the manner shown before. These convictions might conflict with what doctors planned or decided, and, not having had these decisions explained to them, nurses might not understand the negative effects of their actions, and the final care provided to the patient could be less than ideal.

The important question is therefore: is a collaborative relationship between nurses and doctors in Jordanian hospitals possible and applicable?

The following subsections will show that a collaborative nurse-doctor relationship is challenged by many factors, including the public view of nurses and their roles and knowledge, and the mass media.

4. Public views of both nursing and medicine: Reinforcing the nurse-doctor hierarchical relations

The characteristics of Jordan as a male-dominated tribal community, in addition to the rooted view of the role of nurses, seems to reinforce the dominance of doctors and the marginalization of nurses in the nurse-doctor relationship.

The marginalization of nurses' skills and knowledge was reflected by nurses' description of patient and relative expectations of their role as only 'servants of doctors', and in the far greater significance they placed on the medical skills of doctors compared to those of nurses:

"While patients behave rudely with us, they do not utter a word to doctors and complain less. I think this is due to the social view of

nurses as servants...People think that nurses are only the appliers of doctors' orders." (S.N P(10); F; S.M; M.H)"

"... Some patients think that the nurse is a servant... Patients trust doctors and painkillers more than anything else... Patients also trust doctors more than nurses. Patients view nurses as assistants of the doctor. They view the doctor as the essential element of the health care process." (S.N P(14); M; S.M; M.H)

Patients in their turn confirmed nurses' feelings and clearly revealed what they believe the role of a nurse to be:

"I did not expect nurses to decrease my pain because decreasing pain is not the nurses' duty. Nurses' duties are limited to giving the medication that doctors prescribe." (P.T F(P-3); S.F; M.H)

"Nurses cannot do anything without being ordered by doctors. The doctor is the only person who is informed about the patient's case. The nurse's job is only to administer medication, change incision dressings, and measure blood pressure. In other words, if the doctor does not order, nurses do not work." (P.T M(P-13); S.M; M.H)

Because of the inferior view of nurses' roles and knowledge, and doctors' perceived omnipotence, the majority of patients preferred to communicate pain to doctors. Nurses confirmed this:

"... Patients deal with nurses relying on the grounded social view of nurses. Some patients avoid communicating their complaints of pain or other things saying, "Call the doctor, you will not understand what I need..." (H.N P(1); F; S.M; M.H)

"I trust the doctor more than nurses because he is definitely more knowledgeable and more informed regarding my medical condition." (P.T F(P-25); S.F; P.H)

"...The doctor is a doctor; he knows more than nurses." (Observation (5); F; S.F; M.H; Shift (B); 6:00pm)

"No, I did not tell nurses about my pain. I am waiting for the doctor. He will treat my pain. He will tell me why I have pain. He knows more than nurses." (Observation (11); M; S.M; P.H; Shift (A); 9:40am)

"Actually, I do not trust any of the nurses, whatever the length of their experience is. I trust doctors... they are more informed regarding my medical case." (P.T F(P-22); S.F; P.H)

In addition, all patients allowed doctors to physically examine them, but not nurses. This has created further marginalization of nurses' skills and knowledge, as reflected by the observations and reflections of patients and nurses:

"I do not accept being exposed to a male nurse, because checking me is not his responsibility, but it is the responsibility of my doctor whatever the doctor's gender is." (P.T F(P-6); S.F; M.H)

"The problem is that female patients do not accept being exposed to male nurses but accept being exposed to male doctors and medical students. This is attributed to the fact that Jordanians believe that the doctors' job is important, and thus, it is necessary that he checks the patient. Contrary to this, they think that the nursing job is unimportant." (S.N P(8); M; S.M; M.H)

"For me, it does not make any difference to be assessed by a male doctor or a male nurse. However, it is the norms that push me to accept being assessed by a male doctor but not a male nurse... [hmm], I do not know, we are not used to being assessed by nurses..." (P.T F(P-29); S.F; P.H)

So, because of patients' views of nurses' knowledge as inferior, and the low esteem in which the role of nursing is commonly held, some patients did not communicate their pain to nurses, or allow nurses to assess them, but preferred to wait for doctors. This type of action seems to reinforce the hierarchical nurse-doctor relationship in two ways. First, such action shows the doctors' job as being more important than that of the nurse, and thus reinforces the already hierarchical relationship between doctors and nurses. Patients' comments revealed that they were concerned with doctors' knowledge of their pain or condition more than that of nurses. Which thus

leads to a situation in which, as Brown and Seddon have described it “society values the knowledge of the processes of the body far more than the ability to care for the diseased body; ...not only is medicine given more authority, it is also more highly valued than nursing” (1996: 31).

Second, by preventing nurses from accessing their cases or bodies, patients seemed to limit nurses’ access to information and knowledge regarding their conditions. Thus, doctors enjoyed a further point of power by having a level of access granted by patients, which nurses did not.

However, the question then arises, what is the origin of patients’ inferior views of nurses? The historical views prevalent in society have partially governed and shaped the way the public perceives nurses’ knowledge, roles, and more importantly, the nurse-doctor relations:

“The culture: I have been a nurse for 27 years. I have suffered from the poor cultural view of nurses. Being a nurse was a shameful thing, and still is, but this is less obvious now...We live in a patriarchal society. The bad nursing reputation arose a long time ago, when nursing was taught as short course sessions, and most of the nurses were adolescents. You know that adolescents are normally confused and irresponsible. Some of those nurses brought the bad reputation for nursing in Jordan, especially because of their immature emotions toward male doctors. From here, the bad reputation to nursing developed. I always hear people's bad impressions about a female nurse and a male doctor, but not about a male nurse and a female nurse. This is because male nurses were very few in the past ... The bad view of nurses weakens the trust relationship between nurses and patients... The community was just with the doctors but not with nurses for a long time...” (H.N P(51); F; P.H)

The public view of nurses seems to have emerged because of a number of influential factors, such as mass media, the attitudes of some doctors, and other factors related to organization.

For example, nurses said that the image of nurses in the media, through movies, especially Arabic movies, impacted on their image and governed the way patients' perceived their practices and behaviours:

"The Arabic television series and movies strengthen the poor public view of us. In all the movies that I have watched in my life, nurses were shown as bad women who make bad relationships with doctors and patients. The female nurse has always been shown in TV as a woman who leaves home at night to the work, but instead of going to a hospital, goes to a Casino..." (S.N P(3); F; S.M; M.H)

"... Mass media does a disservice to nurses and does well for doctors. Most Arabic movies and films show nurses, especially female nurses, as morally bad, and as being protected by male administrators because of personal sexual relationships." (S.N P(6); F; S.M; M.H)

"Patients are more polite when they talk and deal with doctors than when they talk to us. This thing is grounded in our culture. Multimedia has a role in reinforcing this view in the community. For example, a month ago, I watched a Western movie; it showed a nurse reading a magazine while her cancer patient escaped from the hospital. This definitely suggests that nurses are careless. The effect of Arabic movies is more devastating as they give a bad reputation to female nurses when they show nurses as a mistresses or paramours of male doctors, and that their behaviours are always wanton." (S.N P(59); F; S.M; P.H)

In addition to the role of the media, many nurses said that some doctors behaviour influence patients' views of them. The majority of nurses said that the way doctors treated them in front of patients encouraged patients to underestimate their knowledge:

Nurse: *I want to say that doctors share the responsibility with the mass media for creating a bad image of nurses.*

Researcher: *How?*

Nurse: *They ignore and sometimes insult nurses in front of patients. This makes the patient believe that nurses are the servants of doctors and that their work is only to apply doctor orders. The patient believes what he witnesses because the doctor is always believed and trusted." (S.N P(6); F; S.M; M.H)*

"Doctors do not ask us about patients' conditions, but they ask the patients directly. This indicates an absence of trust of doctors in nurses. I admit that they may be right not to trust us, but they should respect us in front of patients. ... I think that because of their bad dealing with us in front of patients, doctors create a bad image of nurses, and help establish the wrong view that patients have about nurses... Sometimes, doctors deliberately ask a nurse a difficult question to embarrass her in front of patients and to show others that nurses do not know anything." (S.N P(21); F; S.F; M.H)

So, mass media and the behaviour of doctors seems in part to impact on the public view of nurses, as nurses have themselves said. Further findings to confirm the above discussion are introduced in the next section, in addition to a discussion of the role of organization in this area.

Concluding remarks

This chapter explored the hierarchical nature of the nurse-doctor relationship observed in both studied hospitals, based on the marginalization of nurses and overt dominance of doctors. In response to doctors' power and dominance nurses showed three positions: 'disciplined', 'docile', and 'resistant'. The same nurse could select from each of these three positions. All three nursing positions impacted on nurses' practices and hence on patients' pain management.

Nurses in this section often acted only to apply doctors' orders to pain management, and in some instances completely avoided communicating patients' pain complaints or making suggestions regarding pain complaints to avoid provoking conflicts with doctors.

Establishing a nurse-doctor relationship based on bidirectional respect seems to be hard because of the public views which operate to reinforce doctors' positions and limit the possibilities for nurses to use their

knowledge and practices when working with patients. This will be further discussed in the following chapters.

The next section introduces findings related to professional-patient relations and their effect on pain management practices.

Section Two

Professional-patient relations

Introduction

This section presents findings about another aspect of power relations in clinical surgical settings. It shows, in part, how professionals construct their knowledge about patients' pain, and the effect such knowledge has on pain management outcomes. It also introduces findings on the actions of patients' in response to professionals' practices. Understanding this aspect of power relations is important to gaining a fuller picture of the context in which pain management takes place.

1. Relationship between professionals' pain knowledge and pain assessment practices

Interpretative analysis of the data shows that the attitude of the majority of professionals tended to reduce pain from a subjective idiosyncratic experience, to a set of measurable and observable signs. The majority of nurses, for example, when asked to describe their views about pain, offered a definition within medically oriented frames, as a sign of a physiological condition or a nervous response to a damage of body tissue:

"Pain is a negative feeling that the patient feels because of a physiological abnormality or being exposed to an accident or an injury." (S.N P(57); M; S.M; P.H)

"It is the response of the patient during any procedure such as surgery or after falling down, which stimulates nerves. This response varies from one person to another." (S.N P(14); M; S.M; M.H)

“Pain is a nervous impulse that indicates a deformity or injury to muscles, or tissues.” (S.N P(54); F; S.F; P.H)

Only two nurses, among the 29 interviewed, said that pain is a subjective experience that can only be defined in term of the patients’ subjective descriptions:

“Everything that the patient complains of is pain, I think, whether this thing is physical or psychological.” (S.N P(60); F; S.M; P.H)

“There is not a recognized definition of pain. For me, pain is a patient's description of his feeling. Pain is unobservable.” (S.N P(4); F; S.M; M.H)

Professionals’ practices in pain management, such as pain assessment, seem to be partially constructed on the former views. The data show that professionals in both hospitals did not use any type of pain scale to assess patients’ pain severity. Patients’ subjective reports of pain were often marginalized and many professionals assessed pain instead relying on several observable and measurable indicators, such as vital signs and patients’ behavioural indicators, as shown in Box (6).

<u>Box 6: Indicators of pain that professionals relied on to assess patients’ pain</u>	
Indicator	Evidence from the data
Vital signs	“In order to determine if a patient is in pain or not, I rely on clinical signs such as vital signs. I do not rely on the patients' subjective complaint all the time because I do not trust patients. I know that the patient is in pain if his vital signs are abnormal: for example, has tachycardia...” (D.R P(37); M; M.H)
Patient’s facial expressions & behaviours.	“First, from her facial expressions... If the patient is shouting, I start giving her the prescribed painkiller immediately postoperatively. If the patient does not shout, I might postpone giving her the painkiller for an hour, or until she becomes conscious...” (S.N P(53); F; S.M; P.H)

Characteristics of operations	<p>"I do not give Pethidine injections to all patients postoperatively. For example, for patients of simple daily surgeries, I do not give painkillers... Characteristics of operation are another indicator; I mean the length, and depth of the incision. For example, pain induced by an abdominal Laparotomy is more severe than that caused by an appendectomy..." (S.N P(14); M; S.M; M.H)</p> <p>"...Usually, I write a regular order of Pethidine Q6 hours in cases of major abdominal operations, such as laparotomy, but not PRN orders... In cases of minor operations, such as appendectomy & herniotomy, I prefer writing STAT orders... It depends on the length of the surgical incision... The surgical incision of a laparotomy induces more pain than that induced by appendectomy or herniotomy." (D.R 9(68); M; P.H)</p>
The patients' body position and gesture	<p>"... There are some indicators that show that the patient is really in pain, such as screaming, crying, his facial expressions, his body position; some patients do not tolerate sitting in bed, hence they sit on the floor." (S.N P(8); M; S.M; M.H)</p>
The level of patients' activity.	<p>"... I decide whether the patient is in pain or not depending on how active he is; if the patient can walk, go to the bathroom, this indicates that he is free of pain." (D.R P(43); M; M.H).</p>

Moreover, professionals extended the importance of patients' behavioural indicators from detecting if the patients had pain to detecting the severity of pain:

"Nurse: In most cases, I evaluate the pain severity from the patient's facial expressions... I assess pain when I look for patients' facial expressions..."

***Researcher:** How do you know how severe the patient's pain is from his facial expressions?*

***Nurse:** Patients, for example, shout if the pain is severe. Some patients, who do not shout, tolerate pain because it is less severe." (S.N P(6); F; S.M; M.H)*

"From the patient's facial expressions, screaming, or crying. The calm and comfortable facial expression indicates a mild pain." (S.N P(56); M; S.M; P.H)

Behavioural indicators were also important for the majority of professionals when looking for verification of patients' subjective complaints of pain:

"The patient in pain can be easily differentiated from those who claim they are in pain or who has no pain. The patient in pain cries or shouts, with facial expressions verifying their pain." (S.N P(65); F; S.F.; P.H)

"Usually... I think it is enough to look at the patient's face to know if she is really in pain or not." (S.N P(17); F; S.F M.H)

The findings showed that nurses did not use any pain assessment tool to help patients report their pain, and further did not ask patients specifically about pain. To assess pain, in a few cases, nurses asked broad vague questions that did not help patients to provide information about their pain. If patients revealed pain upon such questions, no action was taken:

"The nursing round has been continued even though some patients were asleep or not in their beds. When entering each room, the head nurse (participant 1) just kept saying: "good morning, how are you today?" Some patients answered briefly "good", and some did not answer at all." (Preliminary observation; S.M; M.H; Shift (A); 7:45am)

"The nurse asked the patient, 'what is wrong, uncle?' The patient replied 'I have pain here [pointing to the epigastric quadrant]'. The nurse asked 'do you have peptic ulcer?' The patient replied, 'No, I do not'. The nurse said, 'The doctor did not order any painkiller for you. If the pain is not severe, you might need to wait until the doctor's round to tell him about this pain'." (Observation (2); S.M; M.H; Shift (B); 4:45pm)

"The nurse in charge (participant 2) to a patient with appendectomy, 'good morning, uncle, how are you today?' The patient answered, 'when I cough, I feel pain where I had the surgery.' The accompanying nurse (Participant 1) said, while leaving the room, 'when you feel you want to cough, hold a pillow or a towel and press on the site of the incision, then cough'." (Observation (1); S.M; M.H; Shift (A); 7:35am)

The latter nursing action, when the nurse recommended that the patient hold a pillow and support the site of incision when coughing, was the only

nursing pain intervention which was captured during the 123 hours of observations and the 100 interviews.

From the previous examples one can see that professionals, especially nurses, created a collection of indicators of pain which were observable, and which were verifiable by an outside party. There was no utilization of pain assessment based on patients' subjective experiences and report of pain. Professionals created a 'sensory knowledge' (Foucault, 1975: 149) about pain, failing to acknowledge that calculating such a symptom isolates it from its authentic body and its related contexts.

The educational preparation plays a part in constructing such objective knowledge among professionals in both studied hospitals. The document review of all modules of the syllabus in two nursing schools revealed that there was minimal focus on pain in the knowledge taught to nursing students. In the private nursing school, there was no dedicated session on pain in any of the nursing modules. Instead, it was mentioned as a sign of other physiological health conditions without further discussion. Reviewing the modules' syllabus in the governmental nursing school showed that pain was only taught in one half hour session during the four years of nursing study. Thus, it seems that the university education provided students with little understanding of pain, whether through education or examinations. As the participating professionals said:

"I do not remember the last time I read something about pain. Even in our board examinations and other routine oral or written examinations, pain and its management was not a priority or a topic of focus. Most of the surgeons' examinations focus on pathophysiology of diseases and its treatment." (D.R P(44); M; M.H)

"Pain or its management was not an important issue even in our board examination. Very few questions were asked about pain and its management." D.R P(72); M; P.H)

"I studied less than a chapter about pain during my four years of nursing study. Pain for our scholars was not a priority." (S.N P(11);F; S.M; M.H)

The limited knowledge gained in university education regarding patient pain seemed to have a role in establishing nurses' view that pain occupies a low priority compared with other taught issues. Thus, it seems that the priority in professionals' work was shifted from pain to other observable and measurable signs such as bleeding:

"I think that the observable health troubles, such as bleeding, are more important than pain." (S.N P(2); F; S.M; M.H)

"As soon as the patient is discharged from the operating theatre, I check the patient wound for bleeding... No, not for pain." (S.N P(24); F; S.F; M.H)

From this, one can argue that the knowledge regarding pain and pain management which nurses acquired during their university education was not sufficient to present pain as a priority. Thus, nurses' knowledge about pain management came largely from their experience of working on wards, and was mostly derived from the medical knowledge of the doctors to whom they were exposed frequently.

Not only was patients' pain reduced to observable indicators, but also a patient's body was reduced to a collection of papers and notes that were discussed away from the patients themselves. Patients were partially aware of this reduction and of the professional interest in their case profiles over

their bodies and experiences. This created a feeling of marginalization and of being less important in comparison with other issues:

"The patient is not the axis of nurses' work. They work with papers more than working with patients." (P.T M(P-17); S.M; M.H)

"I hope that nurses would make me feel that I am present and more important than the medical file they read each time they enter the room." (P.T M(P-20); S.M; M.H)

Patients also expressed being unsatisfied with the way nurses fragmented their bodies into a collection of tasks that did not satisfy their pain needs:

"Nurses did not do anything else. They only gave me one painkiller injection in my thigh. The pain was severe, even after they gave me the injection. I almost died because of pain last night. After that, when nurses entered the room, they only checked the intravascular fluids." (P.T M(P-35); S.M; P.H)

"I feel that nurses and doctors here do their basic tasks, only. They do not do anything more for the patients. I mean that nurses come only at certain times to measure blood pressure and temperature, and give medication..." (P.T M(36); S.M; P.H)

"... In general, I want to say that nurses here... only do the necessary works such as measuring blood pressure, and administering medications. They even do not return to the patient to check the effect of the given painkiller." (Observation (12); F Relative ; S.F; M.H; Shift (A); 8:20am)

It was observed that nurses paid more attention to medical profiles more than to patients, which led to a lack of verbal communication between both parties:

"It is amazing how fast nurses enter and leave the room. They spent less than 30 seconds discussing my case with each other, and I feel I am not here. I think they do not recognize my presence!" (Observation (8); M; S.M; M.H; Shift (B); 3:00pm)

"Morning nursing round has started. All nurses stand at the bottom of each patient's bed. All the focus is on the patient's medical file. Up to this point the nursing round has passed through five rooms. No communication happened between the nurses and the patients or

their relatives. In addition, no eye contact occurred between them.”
(Observation (18); S.M; M.H; Shift A); 7:40 am)

“Nurses often speak using English medical terms. They discuss the case very briefly and spend a very short period of time in the room. They talk to each other looking at my father's file. They do not even look towards my father.” (M.Relative (P.T M(P-11); S.M; M.H)

The above subsection reveals that patients’ pain was reduced to a set of facial expressions, and behavioural and physiological indicators. In addition, it was shown that nurses interactions with patients were task oriented and that this prompted many patients to say that they are ignored.

2. Forms of nursing practices that embodied patients’ marginalization

The collected data often revealed a number of practices which conveyed the marginalization of patients, and which thus prevented them from playing an active role in the care given to them.

First, patients were often excluded from the discussions regarding their cases. Frequent use of English and professional terms by nurses led a number of patients and family members to express the view that the nurses’ discussed the patients’ cases in a way which was incomprehensible; monopolized the knowledge regarding their cases, and thus left them in a stressful situation. This effective monopolization over the knowledge of patients’ bodies, may go some way to explaining the feelings of vulnerability expressed by the patients:

“A patient’s relative: Every day, nurses come in to the room three times [meaning rounds], they look at the file, talk in English, close the file and then leave... I thought that they talked in English in order to keep my father's health condition secret.” (Observation (5); M; S.M; M.H; Shift (A); 10:35am)

"...Doctors and nurses talk in English and leave. We do not understand anything. I think that telling him or us about his real medical condition will decrease his and our anxiety." (M.Relative (1); S.M; M.H)

"The relationship with nurses is cold and formal. When nurses and doctors come in the room in the morning, for example, they talk to each other using very professional terms, and they do not explain to us what they are talking about. This of course annoys me because I also want to know about my cousin's case, in order to calm his mother later when she asks me." (M.Relative (P.T(P-35); S.M; P.H)

In interviews, nurses often confirmed patients' views, and said that by speaking in English, they proposed to hide information from patients and their families. However, other explanations were provided by nurses for speaking in English:

"... Nobody has enough time to educate patients since in military hospitals, patients ask many questions. Sometimes we avoid talking in Arabic during nursing morning round since there are some medical faults that should not be revealed in front of patients... Usually, any medical or interventional fault is discussed in English." (S.N P(14); M; S.M; M.H)

"Sometimes we use English words to discuss any medical fault done by doctors. In such a case, we prefer that the patient does not hear from us what is really happening. The doctor is the person who should tell him..." (S.N P(6); F; S.M; M.H)

Second, the lack of patient education, whether preoperatively, or postoperatively, was another way in which patients were marginalized from involvement in the pain management process. Power was imposed when professionals limited the opportunities of patients to gain access to more information about the possibilities for postoperative pain management. By doing so, nurses placed patients in unnecessary pain, as well as fear and anxiety, regarding anticipated postoperative pain:

"... Only today did I discover that pain can be treated by painkillers. I

found this out from a nearby patient who asked nurses for a painkiller injection. I did not complain of pain to nurses because I thought that they cannot do anything to decrease my pain. I wish they told me before as this would have saved me a lot of fear of being in pain.” (P.T M(P-19); S.M; M.H)

“When nurses came and gave me the injection, they told me that it contains Voltaren... In fact, I did not know that pain after my operation could be treated by a medication. Nobody told me about this...” (P.T F(P-2); S.F; M.H)

Both the lack of education and insufficient communication between nurses and patients prompted patients and their relatives to frequently hang around nurses’ stations to get information, and ask for help:

“It was very severe. I kept telling my daughter about my pain. She went to the nurses several times and informed them about my pain, but they refused to respond to her immediately.” (P.T F(P-14); S.F; M.H)

“I went to the nurse’s office about 4 or 5 times and I asked them to come to check my son, but they did not come with me, and when they did come, they said, “be patient, we called the doctor... we cannot give you more than one Pethidine injection a day, you have been given an injection today.” I am wondering why nurses refused to give my son the injection if it can decrease his pain!” (M.Relative(1); S.M; M.H)

“The counter is crowded by relatives who ask nurses about issues related to their patient cases and pain.” (Observation (6); S.M; P.H; Shift (B); 8:00pm)

Third, professionals imposed power when they judged patients’ pain complaints according to their own interpretations, neglecting to ask patients for their perspective. For example, professionals would frequently apply their own interpretations to pain related complaints, judging patients variously as ‘liars’, who ‘exaggerate’ their pain, as psychiatric patients, ‘nagging’ and ‘addicts’. This opened the door for further exclusion of patients from involvement in the pain management process during

hospitalization:

"Some patients' visitors are very 'nagging'(sic). They come to the counter frequently to ask for painkillers for the patient they are visiting. They do not understand that the patient may have been given a painkiller just an hour before their arrival." (S.N P(52); F; S.M; P.H)

"Today, when my sister told the doctors that she has had constant severe pain for four days, one of the doctors said that she must be 'psychiatric', or maybe she fought with her husband, and that is why she is seeking attention." (F.Relative (1); S.F; P.H)

"After the doctor left the patient's room, he said: This patient must be 'psyche'. She has 'DM'. Maybe she thinks she has pain, but does not really have pain because diabetic patients do not feel pain at the site of an amputation." (Observation (6); S.F; P.H; Shift (B); 7:30pm)

"... People exaggerate their pain in order to make the doctor believe them. They lie regarding their pain severity just to gain more attention from doctors. Hence, I do not rely on patients' subjective complaints of pain ..." (D.R P(41); M; M.H)

"A patient, first day post herniated intervertebral disc operation, came to the head nurse office, putting his hand on his back and leaning forward a little, 'I need a painkiller, I feel pain, please, I feel that my back is like a hard surface'. The S.N (P-8), said: 'You are not serious, you are lying" (Observation (15); M S.N & M P.T; S.M; M.H; Shift (B); 2:55pm)

"... Most of the surgical cancer patients are 'addicts'; hence we avoid responding to their complaints because we know that they need Pethidine because they are addicted, not because they feel pain. ..." (S.N P(6); F; S.M; M.H)

In response to nurses' judgement of them, patients showed a decreased willingness to communicate pain because they did not want to be seen as complainers, especially when nobody believed their pain. As some patients said:

"The patient wants to avoid being seen as a complainer, especially in front of a doctor, who might say that she is magnifying her pain..."(F.Relative (1); S.F; P.H)

"When a nurse or a doctor does not believe the patient's complaint,

this inhibits the patient's willingness to inform them about his pain. Also at home, if the patient feels that nobody appreciates his pain, he will try to hide his pain.” (F.Relative (P.T(P-26); S.F; P.H)

On the other hand, some professionals used dishonesty and deception to apply their own interpretations to the pain complaints of patients. In this way, professionals used their ideas about patients’ pain as a source of power over them. Fainzang (2005) uses the concept of deception in a way which could be usefully applied to the following examples, arguing that deception “expresses a position of power, even if it aims to be beneficial and positive for the patient. [Professionals] use their position of power to produce a discourse where the truth is deliberately hidden from the patient,” (2005: 38). Examples of deceptive behaviours nurses showed or revealed appear from the following quotations:

“...Sometimes, I put Buscupan ampoules with Pethidine ampoules in the locker of the narcotics. When any patient asks for a painkiller, I draw an ampoule of Buscupan instead of Pethidine. The patient will definitely believe me because I have drawn an ampoule from the narcotic drugs' locker. Patients know that narcotic's locker contains only narcotics, nothing else.” (S.N P(6); F; S.M; M.H)

“Yesterday, a nurse gave me a medication intravascularly, and said "this is a painkiller". When my brother read the file, he said that what I was given is an antibiotic not a painkiller.” (P.T F(P-29); S.F; P.H)

“We can discover whether patients are addicted or not by giving them distilled water instead of Pethidine. If the patient stops complaining they are addicted, and their pain is not real.” (S.N P(65); F; S.F; P.H)

“We usually rely on analgesics only. If the patient continues complaining of pain after the first dose of Pethidine, I trick him by giving him an injection of Allerfin (Chlorphenamine)...”(S.N P(52); F; S.M; P.H)

Limiting the access of patients to information about their cases or the anticipated postoperative consequences of their surgery or using deception serve to place patients in a weaker position in relation to nurses.

3. Forms of nurses' disciplinary actions

In response to patients' frequent enquiries, nurses displayed deliberately disciplinary actions to discourage such behaviours, as well as impose further power over patients.

- In a way similar to other cases of research in the nursing literature, many patients highlighted nurses' irritability or abrupt behaviour when they complained of pain:

"Some nurses are irritable and pretend to have forgotten a patient's complaint of pain. Patients keep suffering until a good nurse comes." (S.N P(14); M; S.M; M.H)

"In addition, some nurses get annoyed; when I ask for something from them, they say, 'Do you see me playing? Just a minute'...It happened twice that my mother-in-law kept shouting at night because of pain, and a nurse came and said, "why do you shout, it is enough, keep silent." (F.Relative(3); S.F; M.H)

"One of the nurses said, without looking to the relative's face, 'Ok sister, we are coming, wait, wait, do you not see we are busy. Do you think we only look after your patient?" (Observation (1); F; S.F; P.H; Shift (A); 9:15am)

Because of such nurses' responses, it seems that some patients avoided communicating pain to nurses in order to avoid interrupting their tasks:

"I know that nurses are busy. I know that I am not alone in the ward and that many patients suffer pain. I think that nurses fail to care about me because they are busy with the very crowded ward of patients." (P.T M(P-15); S.M; M.H)

" At night, I could not sleep well. I woke up several times because of the pain. I kept walking late at night in the corridor, especially in

front of the nursing counter, but the nurses did not pay me any attention. Maybe they are tired and their number is not enough to offer services to all patients.” (P.T M(P-34); S.M; P.H)

Nurses’ impatience clearly decreased patients’ willingness to communicate their pain. This means that patients *interiorized* the professionals’ irritable behaviours, resulting in further exclusion:

“H.N: I think that kind communication with a patient is an effective way of pain management. However, some of the patients do not reveal their pain to some nurses because they are afraid of them.

***Researcher:** Why do you think patients are afraid of some nurses?*

H.N: Because some nurses are irritable and scream at patients. Thus, patients avoid provoking nurses' annoyance by keeping silent...” (H.N P(1); F; S.M; M.H)

“... It happened with me during the last few days, that my son asked me frequently to go and inform nurses about his pain. Nurses were fed up and got angry. Thus, when my son asks me to inform nurses about his pain, I leave the room, but I do not go to nurses' room and I do not inform them. I feel hesitant because of their abrupt response, and I am an old man, I do not want to hear a bad comment from any of the nurses.” (M.Relative(1); S.M; M.H)

“I did not ask for a painkiller, as I told you before, because I do not want to get into trouble with the nurses; they are irritable” (Observation (17); M; S.M; M.H; Shift (B); 3:45pm)

- Ignoring frequent patient complaints of pain, or relatives asking for painkillers for their family member, was another practice with which nurses disciplined patients and their relatives:

“I cannot give their patient Pethidine frequently; hence, they keep nagging for Pethidine. I always deliberately delay responding to nagging relatives to teach them a lesson.” (S.N P(10); F; S.M; M.H)

- Nurses sometimes frightened patients with the potential complications or side effects of painkillers. This type of disciplining practice was particularly effective at reducing patient complaints or requests for

painkillers:

"When a patient asks for Pethidine, I say 'taking Pethidine frequently causes addiction. Addiction is more dangerous than the pain you feel now. Can you not tolerate pain?' In this way, he will not ask for Pethidine any more. Sometimes, if the patient asks for Diclofenac Sodium (Voltaren), I say, 'frequent use of Voltaren causes renal failure'...If a patient's family resists and asks for Pethidine frequently postoperatively, I tell them that taking Pethidine more than once every eight hours causes addiction." (S.N P(6); F; S.M; M.H)

"If patient's relatives are 'nagging', I tell them that giving pethidine frequently to a patient is harmful, and I ask the patient to tolerate the pain. Some painkillers, like Voltaren, harm the patient's health if administered frequently." (S.N P(13); F; S.M; M.H)

"I might offer support by telling her that her feeling of pain is normal and to be patient and to tolerate pain because a lot of painkillers cause addiction." (S.N P(62); F; S.F; P.H)

The main issue derived from the above quotations is that nurses used their position and knowledge to build a certain conviction among patients regarding painkillers, especially narcotics. The messages conveyed from professionals about the side effects of painkillers showed a significant influence on patients' thoughts about painkillers, and further influenced negatively their willingness to communicate their pain:

"After the nurse gave me the painkiller injection, she said to me 'we cannot give you more than two painkiller injections every 24 hours because it causes complications and its effects last for eight hours'. Thus, I avoided complaining of pain and did not ask nurses for a painkiller until now." (P.T F(P-3); S.F; M.H)

"... meanwhile, a nurse was in the room administering the I.V fluid for a renal colic patient. She said, 'if you take it [pethidine] three times or more, you will become an addict'. The renal colic patient said 'you should have told us before that it causes addiction, so that we would not ask for painkillers frequently. Now, since you said this, I will not be nagging for a painkiller. Telling us, you will save yourselves the effort of refusing to give us painkillers." (Observation (16); S.M; M.H; Shift (C); 9:35pm)

The above quotations provoke a question regarding the part played by nurses in the construction of the wider public attitude to painkillers. Conveying messages that frighten patients about the side effects of painkillers displays their role in the indirect *governmentality*, through which the public's beliefs about painkillers are in part constructed. Arguably, such beliefs might be transferred to the wider society through patients after discharge. Some patients' relatives said that they prefer not coming to the hospital because of fear of the side effects of painkillers:

"Personally, I would prefer tolerating pain rather than going to the hospital to avoid taking medicine because people, doctors and nurses say that taking drugs frequently is dangerous and causes serious complications." (M.Relative (5); S.M; M.H)

Not only were the verbal messages conveyed by professionals about painkillers influential, but also their non verbal communications. For example, in both hospitals, there was a large poster on the narcotics locker on which was written 'poisons', clearly indicating that the contents were toxic. The narcotics lockers were visible to patients and their relatives:

"The narcotics' locker is present behind the nursing counter beside the desk; and written on it with a big bold font 'POISON'." (Observation (1); S.M; P.H; Shift (A); 9:00am)

However, the motive for frightening patients away from painkillers still needs further illumination. By emphasising the potential side effects and complications associated with painkillers, nurses deliberately deceived patients in order to avoid administering painkillers. Nurses' fear of the side effects of painkillers, whether addiction, respiratory depression, or deep vein thrombosis might be the cause of their continuous avoidance of administering the drugs in question, and thus their motivation to frighten

patients of them:

"We do not give Pethidine to patients each time the doctor orders us to give Pethidine, since we fear addiction if the patient is given Pethidine frequently. Some patients become addicted from the first injection of Pethidine. Currently, there is a surgical cancer patient in the ward who asks for Pethidine every three hours, but we refuse to give her the injection because we know she has become an addict." (H.N P(16); F; S.F; M.H)

"If the patient is complaining of pain, I wait for a while; I do not give her the prescribed painkiller, for example Pethidine, immediately after she arrives on the ward. Instead, I wait until the effect of the anaesthesia fades from her body. I wait for half an hour or an hour depending on the patient's pain severity. I am afraid of placing the patient at risk of DVT if she was given Pethidine immediately post operation, since she will stay drowsy in bed." (S.N P(24); F; S.F; M.H)

"I think that the patient should be given his ordered painkiller after 30 minutes or one hour. I do not give it immediately when the patient arrives at the ward because ... Pethidine increases the probability of respiratory depression." (S.N P(56); M; S.M; P.H)

Knowledge deficit and a lack of nursing educational preparation regarding painkillers might be another explanation for nurses' fear of these side effects. As some nurses said:

"...Some nurses also have this inaccurate idea about Pethidine and other narcotics. I think that the cause of the wrong ideas about Pethidine and other narcotics is a lack of knowledge... This is attributed to the way that nurses learn about painkillers and narcotics at university. Most nursing students do not dare to look for the locker of the narcotics. Their instructors frighten them about addiction and respiratory depression. I have been here for 16 years, during which time I have never seen an instructor teaching students how to deal with narcotics..." (H.N P(1); F; S.M; M.H)

- Some nurses told patients that pain is "a normal feeling post operation", and asked them to tolerate it. This action also seems to have been prompted by nurses' fear of the side effects of painkillers as they said:

"For example, I talk to the patient and say, 'you should tolerate the pain, if the pain does not fade within the next hour, come and inform me...'. Sometimes I say, 'pain, which occurs post operation is not frightening and alarming, it is a normal feeling...'. In this way, the patient will not ask for a painkiller as frequently as before."(S.N P(8); M; S.M; M.H)

"I ask the patient to tolerate the pain, and meanwhile to move or to walk. I ask the patient to tolerate the pain in order to avoid being given frequent doses of painkillers because this might develop into a psychological tolerance, even for other painkillers such as Voltaren." (S.N P(54); F; S.F; P.H)

- Some nurses encouraged physical activities for patients as a way to distract them from asking for painkillers frequently. For example, some nurses asked patients to walk, to change their position, or to sleep to decrease pain, without any further action to manage patients' pain:

"S.N to a patient: ... you have been given anaesthesia when you were in the OR, when you finished your operation...you should wait at least another four hours before I can administer Pethidine to you. Try sleeping." (Observation (15); F; S.M; M.H; Shift (B); 4:30pm)

"When a patient asks for painkillers frequently, I ask him to tolerate the pain, and meanwhile to move or to walk." (S.N P(54); F; S.F; P.H)

So, knowledge deficit might be a factor that prompts nurses to say that pain is 'a normal feeling' post operation. In addition, the organization seems to influence the way staff perceived patients' complaints. The influence of the organizational culture was particularly apparent in the military hospital. Multiple observations revealed that nurses dealt with patients' pain by relying on their military perceptions, underestimating patients' self reports of pain:

"S.N (8): 'His operation is not serious. It is only a small wound and does not deserve all of this complaining...Those patients, especially

those who work in the central command, behind desks are spoiled and feel the mildest pain as severe. They are not used to doing the harsh work'." (Observation (13); M; S.M; M.H; Shift (B); 7:40pm)

As mentioned earlier, some patients showed reduced willingness to communicate pain, and tended to be stoic upon being told that painkillers cause addiction, or that pain is a normal feeling. However, patients' responses to professionals' practices were not always passive, experienced in silence or experienced by internalizing of professionals' actions. Because professionals' practices asserted trends of power, some patients' practices embodied resistance.

4. Patients' resistance to the professionals' actions

The refusal to provide painkillers in response to patients' subjective complaints and other actions through which professionals imposed their own interpretations and knowledge on patients' pain complaints, prompted many patients to take actions of resistance to deal with their pain. Such actions involved breaking the rules of the hospitals by taking their own medications, or even the medications of nearby patients:

"Patient (42 years old, 4th post Hernioplasty) : 'I still have mild pain. On the day of the operation, I suffered severe pain, a pain that ruins mountains, I cried and screamed, begging for a painkiller, but none of the nurses came. After six or seven hours, they administered a Voltaren suppository. That was the only time I have been given a painkiller. Thus, after that I gave up asking nurses for more painkillers, and I asked my relatives to buy a painkiller from outside the hospital... Neither the doctor nor the nurses know that I bought Ibuprofen tablets. Since that day, I have taken a tablet of Ibuprofen after each meal and whenever I feel pain...I am more comfortable doing this than asking for a painkiller from the nurses." (Observation (5); F; S.F; M.H; Shift (B); 5:20pm)

Patients mostly took their painkillers during night shifts, especially when nurses tended to leave patients without a follow-up:

"12:00MN : nurses are taking their dinner in the head nurse's office. There is no movement in the ward. I left the ward for another ward for an hour in order to see what the nurses will do during my absence. I returned at 1:20 am... I searched for all the nurses on duty in the ward but did not find anybody in the patients' wing... In room[x], a patient, post appendectomy, is still awake because of the noise and moaning made by a nearby patient. The mother of the moaning patient said, "I have been to the head nurse's office but did not find any nurses. My daughter is still in pain, I asked the patient in the next bed for a painkiller and she gave me two Paracetamol tablets. She brought them from home. " (Observation (7); S.F; M.H; Shift (C); 12:00MN)

Other patients expressed resistance to professionals' actions by asking for early discharge from the hospital because they felt that their pain was not assessed frequently:

"They only gave me some medication and measured my temperature and blood pressure. I do not need their medication. I want to be discharged from this... hospital." (P.T M(P-16); S.M; M.H)

"Doctors, most of the time, are late when we phone them to come and check a patient's pain. I witnessed some patients asking for a discharge because they were not checked for their pain." (S.N P(56); S.M; P.H)

The resistance of patients and their family was particularly serious when they expressed it in the form of violence, whether verbal or physical. For example, many patients, through interviews or observations, described professionals' characteristics in ways which exhibited their dissatisfaction at being marginalised and ignored. Such characteristics were: 'careless', 'hardhearted', 'angels of hell', 'arrogant', 'liar', and even 'devil' as the following Box (7) shows. Such descriptions appear to represent a

questioning of professionals' behaviours and actions. This questioning may be seen as an expected result of the lack of patient involvement in the care process and a lack of education, as presented earlier.

<u>Box 7: Characteristics patients used to describe nurses</u>	
Characteristic	Patients' words
Careless	<i>"I told you before that I fight and shout continuously at nurses because of their carelessness... They know they are careless and I always tell them they are careless and irresponsible" (F.Relative(3) ; S.F; M.H)</i>
Hardhearted	<i>"Actually, I deliberately did not to show my pain after nurses refused to give me a painkiller. I am shy, and I hesitated to tell them about my pain frequently, especially as they are tough, and they do not encourage the patient to talk about his feelings. Female nurses in all hospitals are hardhearted, although they are called angels of mercy." (P.T F(P-25); S.F; P.H)</i>
Angels of hell	<i>"Nurses who work here are hardhearted. They are supposed to be angels of mercy but they are not. They might be angels, but angels without mercy; They are angels of hell." (Observation (3); F; S.F; P.H; Shift (C); 11:00pm)</i>
Arrogant	<i>"The relationship between me and the professionals that deal with my father-in-law is not good, and not deep. The nurses' care is bad when they come into patients' rooms, and when I ask them for something. They respond roughly. Sometimes, they are arrogant, and they think they are superior to everybody in the room." (M.Relative (P.T(P-33); S.M; P.H)</i>
Liar	<i>"The patient shouting at a male S.N (Participant 8) 'You... are lying. You told me that you will dress my wound and give me a painkiller, when I saw you an hour ago, but you did not.'" (Observation (15); M S.M & M P.T; S.M; M.H; Shift (B)</i>
Devil	<i>"Here, there is a nurse who is the devil herself. She came more than once when I was visiting my mother last time, and threw painkiller tablets on the table and asked me to give them to my mother without one more word. She did many other things that I do not want to talk about..." (Observation (12); S.F; M.H; Shift (A); 9:00am)</i>
Inhumane	<i>"Female nurses who work in this place are inhuman. They</i>

lost their humanity. When I was admitted here, one of the female nurses asked me to sign the informed consent form. I hardly can read and thus I asked her to clarify its contents, but she replied, "You sign or you leave for another hospital." Because there was no other choice, I signed." (Observation (13); M; S.M; P.H; Shift (A); 10:00 am)

In other instances, patients' anger and dissatisfaction with nurses' ignorance of their pain turned critical when it was expressed physically against nurses:

"Yesterday... I experienced severe pain for five hours but none of the nurses acted to stop this pain. I was exhausted and my brother was very angry. At one stage my brother wanted to hit the nurse because he did not appreciate the feelings of a relative seeing his family member in pain. My brother was also angry because the doctors came only during their morning round..." (Observation (4); M; S.M; M.H; Shift (A); 10:00am)

"The A.N has been to the patient's room and, in the presence of four of his visitors, without informing the patient about the injection type or included medication, asked the patient to expose his backside [Gluteus Maximus]. The patient asked 'What is this?' The A.N replied, 'this is a strong painkiller, it even relieves the pain of a camel'. The patient's partner said, 'this is the third time today nurses have given him Pethidine. It must be having side effects'. The A.N replied 'This is what the doctor ordered for him, do you know more than the doctor?'. At this point, the patient's partner became angry and said 'I am just asking, there is no need to be angry like this, who do you think you are? Tomorrow I will tell the manager of the hospital about this', and he moved toward the A.N and raised his hand to hit him. The A.N replied 'Do as you wish', and left the room." (Observation (3); S.M; M.H; Shift (C); 10:15pm)

"When I was telling them that my mother-in-law was complaining of pain, they said, 'We are waiting until the doctor comes.' Sometimes, I shouted in their faces in order to force them to come with me. Until now, I have fought with them about three times because of their carelessness." (F.Relative(3); F; S.F; M.H)

Close reading of the previous patients' words show that violence was directed primarily at nurses but not at doctors. This might be attributed to the deep rooted social esteem in which doctors are held, reinforcing further

the superior position of doctors in the system (Chapter Seven, Subsection [II, 2.4]; Chapter Five, Section One, Subsection 4). However, nurses often blamed doctors for the poor image that patients have of them. For example, some nurses said that the inconsistency between orders that doctors give in front of patients, and those they really write down, causes difficulties and leads patients to think of nurses as ‘hardhearted’ or ‘irresponsible’:

“Doctors like to show their mercy, especially to the private patients, and place nurses in an embarrassing situation with patients. For example, today, one of the patients told Doctor X that she is in pain. Doctor X, in front of the patient, asked me to give her an injection of Pethidine, and then he left. Doctor X gave the order verbally but did not write it down; hence I did not apply his order. The patient said that I am ‘hardhearted’, and that I am ‘careless’ regarding the doctor’s order. I tried to explain to her, but she refused to listen to me and threatened to complain to the manager. When I called the doctor and asked him to return and to sign an order, he refused and said, ‘the patient is not in need, try to shut her mouth with anything’. This real example happens many times a day, and shows us as careless nurses, while it shows the doctor as a merciful person...” (S.N P(23); F; S.F; M.H)

“Sometimes doctors give verbal orders in front of a patient which are different from the orders they write down. For example, one of the doctors ordered me to give a Pethidine injection, but he changed his mind later and wrote Diclofenac Sodium instead of Pethidine, hence I gave the patient Diclofenac sodium. When the patient asked me about the type of injection, I answered, “It is Voltaren”. She became angry and said, “You must inject me with the Pethidine injection that the doctor ordered for me. I will complain to the doctor next time I see him” ... Doctors establish a bad image for us in front of patients. We appear careless ...” (S.N P(22); F; S.F; M.H)

Concluding remarks

This chapter argues that nursing pain assessment practices and management are lacking. The nurses observed did not use pain scales, and excluded patients’ self-reports of pain from their considerations. To assess pain, nurses relied mostly on patients’ vital signs and behavioural indicators,

which were also used to verify patients' complaints of pain and to measure severity. In other words, nurses relied on observation but rarely asked patients directly. Depending on observation, not on *gaze* (Chapter One, Section Two, Subsection 1), meant that no further analysis or decision making was carried out by nurses other than assessing pain through objective indicators.

To manage pain, nurses used practices that asserted their power, and marginalized and disciplined patients. To manage patients' pain, nurses frightened patients with the side effects of painkillers; told patients that pain is a normal feeling postoperatively; or asked patients to do physical activities or to sleep. Some nurses avoided giving the prescribed painkillers, and in some instances, they modified doctors' orders according to their own convictions and fears about painkiller side effects.

Patient practices in relation to postoperative pain varied from expressing pain verbally by crying and shouting, to hiding pain as they *interiorized* a fear of painkillers, or *interiorized* the abrupt responses of nurses; to hanging around the nursing station asking for painkillers and information regarding their cases. In other instances, patients showed resistance to the practices of professionals and took their own painkillers. Some patients felt provoked to verbal and physical violence against nurses. Finally, it was demonstrated that doctors might be a partial cause of the poor image of nurses among patients.

The next section will show that socio-cultural context also has a role in reinforcing a poor image regarding nurses. A more expanded understanding

of the socio-cultural and organizational contexts in which professionals and patients operate might shed further light on the factors which influence the actions of patients and professionals, and which affect their intentions.

The influence of the socio-cultural context

Introduction

This chapter introduces findings related to the influence of the socio-cultural context on the practices and interactions of professionals, patients and relatives involved in postoperative pain management.

This chapter focuses on participants' accounts relating to the role of the socio-cultural context in constructing their gendered subjectivities (attitudes and actions), and reproducing the patriarchal environment in hospitals. Other related socio-cultural issues, some of which emerged unexpectedly, such as patients' visiting customs and the use of personal influence (*wasta*), will also be outlined. This chapter will also present data to show the influence of cultural context on nursing professionalism within organizations.

1. The effect of socio-cultural context through “sexual surveillance”

Sexual surveillance means that “any social relation between a woman and a man sparks off assumptions that sex is at the root of it” (Hollway, 1994: 256). Although the ‘influence of gender’ or the ‘influence of gender relations’ would have been apt names for this section, ‘sexual surveillance’ was the term selected to describe the issue under discussion since, as Hollway explains, it is the assumption of sexual interactions which is the

most salient factor in these interactions. According to my data and analysis, surveillance was imposed, whether by individuals or collectively by the public, because of concern over the potential development of prohibited sexual interactions between men and women, in contravention of custom or of traditional laws (*Urf*) developed to maintain family honour (Chapter Two, Subsection 5.3).

This type of concern has imposed its disciplinary influence on nurses at an institutional level. That is, it influenced their practices and their attitudes to patient pain and its management by limiting their willingness to involve themselves in the pain management of patients of opposite genders. For example:

"I think that pain management is impeded by our cultural traditions, which impede female nurses from getting deeply involved in the care of male patients." (S.N P(4); F; S.M; M.H)

The culturally established gender boundaries impeded a wide range of nurses' practices through restricting access to the bodies of patients of the opposite sex. For example, nurses reported avoiding examining such patients physically, saying that this conflicted with the traditions and norms that limit the ability of females to expose or inspect the bodies of male patients:

"I only do an inspection while I am distant from the patient, for surgical incisions in hands, arms, feet, face, and head. Otherwise, I do not do any assessment of the patient..." (S.N P(10); F; S.M; M.H)

"As a female, I feel shy of assessing male patients. Physical examination is omitted by nurses in Jordanian public hospitals." (S.N P(53); F; S.M; P.H)

"Actually, I do not do any assessment of patients' pain, especially physical assessment because of the workload, and because of my

gender. I am a female nurse, and I feel too shy to assess male patients. I do not do it for religious and cultural reasons.” (S.N P(52); F; S.M; P.H)

“In a room of two patients in the private wing, the Colonel doctor exposed the abdomen of the patient... The S.N (Participant 13, female), immediately, turned her face in the opposite direction, and left the room. After the doctor finished the physical exam, the nurse returned to the room.” (Observation (10); S.M; M.H; Shift (A); 9:20am)

Although physical examination is not essential for pain assessment, it becomes essential if the patient makes frequent complaints relating to his wound. However, the restrictions of cultural traditions discourage nurses from assessing male patients’ surgical wounds:

***“Researcher:** ...Is there any policy that prevents female nurses from doing the physical examination of male patients postoperatively?*

***Nurse:** No, there is not. However, our cultural traditions and customs are the preventing factor. I feel shy from looking at a male's exposed body. I turn my face to the opposite side. Some patients do not accept being exposed in front of a female nurse.” (H.N P(1); F; S.M; M.H)*

“My father developed painful bedsores on his back because of immobility. None of female nurses discovered the bedsores because they do not do a close physical examination of male patients...” (M.Relative (P.T M(P-11); S.M; M.H)

Furthermore, all female nurses, without exception, avoided administering intramuscular injections of painkillers to male patients. If this was required, they gave intramuscular injections in the thigh or deltoid muscle, whatever the muscle mass of the patient was, and whatever the volume of the dose:

“... I avoid giving the injection in the buttock since some patients consider it a ‘private area’... Our cultural traditions regarding gender are very strong, and I cannot break them. I am a female nurse, and I cannot talk, discuss, touch, or inject a male patient. I keep my relationship with males very formal...” (S.N P(10); F; S.M; M.H)

"If the patient complains to me of pain, I leave him without any comment, and tell a male nurse to check the patient...However, if male nurses are unavailable, I give Pethidine injections in the thigh instead of the buttock..." (S.N P(3); F; S.M; M.H)

"If there is an order, I ask one of the male nurses to give the injection of Pethidine to the patient. If a male nurse is unavailable, I give it in the deltoid muscle." (S.N P(13); F; S.M; M.H)

Doing this, nurses ignored hospital rules that stated pain should be assessed and painkiller injections administered regardless of patients' gender. This indicates that the cultural traditions were of a greater influence on nurses' practices and attitudes than the professional and institutional rules:

"... Several weeks ago, the nursing manager released a martial order, which ordered female nurses to administer I.M injections to male patients similarly to male nurses. Female nurses, including me, refused this order. This hospital policy goes against the tide. Thus, it was not applied and withdrawn... I think that more male nurses should work in the male departments. This saves the female nurses much embarrassment, and saves the patients much silent suffering or shyness..." (S.N P(3); F; S.M; M.H)

"It is impossible for me to administer I.M injections to male patients. Even if I accepted, the patient would refuse. In this hospital, it is difficult because we receive patients mainly from villages where people do not accept such a thing, also it is unacceptable culturally. The manager of nursing released a martial order ordering nurses; whether females or males, to administer medication to patients of both sexes with the same degree of acceptance, but none applied this order...we cannot change society's traditions by a written order." (Observation (4); F; S.M; M.H; Shift (B); 7:00pm)

"I refused to apply it, of course. I cannot ask a male patient to expose his buttock to give him an I.M injection. No, no, this martial order is against my beliefs and traditions..."(S.N P(6); F; S.M; M.H)

Paradoxically, although the policy stated that painkiller injections should be administered regardless of patients' gender, other parties within hospitals served to reinforce sexual surveillance. Many nurses refused to apply such

policies because, while on the one hand they were exposed to the wider public sexual surveillance practices of patients, relatives, and other professionals (as will be shown below), on the other, nurses were also not protected against the sexual surveillance practised by the military intelligence agency. Many female nurses said that their actions with male patients were monitored by agents of the investigative agency, and this further restricted their involvement in patients' care:

"... But I cannot apply any procedure that includes touching male patients' bodies since this is questionable and refused by the culture and military intelligence agency.... Policies that limit the contact between female nurses and male patients have a negative influence on the intention of nurses to be friendly with patients." (S.N P(2); F; S.M; M.H)

Working on different shifts also impacted upon the way in which female nurses performed their tasks. Nursing assessment of surgical patients during night shifts was often ignored in male wards because female nurses were embarrassed about entering patients' rooms:

"...In general, our cultural traditions are very influential in determining the relationship between female nurses and male patients. I behave formally with patients as I told you... I do not like working on shift (C). The night shift limits my ability to deal with patients because I cannot enter their room as freely as during the day shifts." (S.N P(13); F; S.M; M.H)

"I like working on all shifts. But, in the male ward, I prefer working on day shifts, and I avoid entering patients' rooms after 11:00pm. It is shameful for a female nurse to enter a male patient's room at night, because while they are asleep they might be exposing some parts of their bodies unintentionally." (S.N P(59); F; S.M; P.H)

The socio-cultural context also impedes the application of pain management techniques nurses may have acquired during their university education, such as therapeutic massage, supportive touch, and even making jokes with

patients. The document review carried out in the two nursing schools revealed that pain management techniques were derived from Western textbooks. Nurses said that these techniques were inapplicable in terms of Jordanian culture:

"I need to know what other actions can be taken for the patient before we call the doctor to write an order of painkiller.... At university we studied simply the definition of pain, and something I do not remember about non-pharmacological approaches like praying. I forgot everything I learned at university since it is not applied in the hospital because of our traditions and customs which forbid female nurses from dealing closely with male patients. In addition, our people believe in medication more than anything else." (S.N P(4); F; S.M; M.H)

"For example, I know that massaging might be effective, but I cannot apply any procedure that includes touching a male patient's body since this is questionable, and refused by the culture and military intelligence agency... We are nurses, but we are distant from real nursing. In this place, we rely hugely on the accompanying relatives of patients to work with patients." (S.N P(2); F; S.M; M.H)

"... I said earlier that my gender as a female further constrains my nursing work with male patients. I might apply supportive touch for kids and babies, but not for young or adult males. I might also do it for older female patients because they are weak." (S.N P(52); F; S.M; P.H)

The majority of patients wanted to be treated with such pain management techniques, except if they were to be implemented by professionals of opposite gender:

"I prefer telling female nurses about my pain, since I feel uncomfortable if a male nurse touches me, gives me medications, or talks to me. I feel discomfort because in general, Arab women are shy. I also think that because female nurses are available, there is no need, and it is questioned, to be checked and cared for by a male nurse." (P.T F(P-3); S.F; M.H)

"Researcher: How would you interpret a nurse's (same gender) supportive humour or touch?

Patient: *I think this would improve my psychological status and would raise my spirits. I am so sensitive, hence, such tiny details are very important to me, and they influence me.*

Researcher: *How would you interpret a nurse's (opposite gender) supportive humour or touch?*

Patient: *... Maybe if the nurse is old, I might accept this action from him because I will feel that he is applying it to me as a father. This also applies to doctors. Otherwise, I refuse it." (P.T F(P-25); S.F; P.H)*

"Actually, I am shy of women. If a male nurse exposed my wound or talked to me, it would be more familiar. When female nurses entered the room, I asked them to call a male nurse for me". (P.T M(P-31); S.M; P.H)

Two causes underpin these attitudes which nurses feel with patients of opposite gender. First, there is the idea that a patient who asks for help might have sexual intentions and might view them as a sexual object:

"People might misinterpret the actions of nurses, for example, when a female nurse tries to help a male patient. This is attributed to the grounded view of nursing in their minds. Even if the patient is respectful, I cannot know his real intentions or the way he interprets things"(H.N P(51); F; P.H).

"Our patients are liars... They claim pain in order to talk with a female nurse and see her back while she is giving an injection, or while she is assessing the wound." (S.N P(3); F; S.M; M.H)

Nursing *interiorization* of the idea that any male patient's request for help is underpinned by a sexual intention had created an atmosphere of profound suspicion and a lack of trust between female nurses and male patients and relatives in both hospitals.

The second cause which was expressed by nurses as affecting their interactions with patients of opposite gender was fear of public misunderstanding and misinterpretation of their actions. These fears worked as a "Panopticon" (Foucault, 1980: 147) in which the 'guard' was the

surrounding people whether patients, visitors, or even other male professionals.

The majority of nurses said that patients and relatives exercised surveillance, sometimes unintentionally, and that this was the reason why it was impossible to apply nursing interventions, such as assessment of the body, supportive touch, or giving I.M injections, to patients of opposite gender. Fear of sexual surveillance and a fear of misinterpretation had developed a culture of *self-surveillance* among nurses, who reported these fears and reflected them in their practice:

"Our culture also has a great hindering influence. I cannot work with male patients properly because I fear they might misinterpret my actions..." (S.N P(53); F; S.M; P.H)

"In a room of five beds, the doctors asked the nurse to close the blinds so they could start assessing the wound of a patient with inguinal herniohaphy. The S.N P(2) closed the blinds and stayed outside waiting until the doctors finished assessing the patient's wound. I asked her about this action, and she replied "I always stand with doctors if I am in a room with a single bed, but in crowded rooms, I avoid that because other patients criticize the nurse who looks at patient's exposed bodies." (Observation (18); S.M; M.H; Shift (A); 9:00am)

"... I think that it is good that a female nurse deals only with the female patients, and a male nurse deals with male patients. Male patients always misinterpret female nurse's actions and behaviours. That is why I avoid deep involvement in their care. Also, I feel that it is difficult to deal with young male patients, especially because I am young too. Most young patients are rude and any intervention will be misunderstood by others in the same room, whether they are patients looking nearby or relatives..." (S.N P(59); F; S.M; P.H)

The presence of other people was not necessary, and was not what always led nurses to fear misinterpretation. The findings suggested that nurses had developed a self-surveillance, and embodied the cultural norms that identify

boundaries of male-female interactions in their job even when others were not present in their surroundings:

"...Sometimes, I postpone giving a patient a dose of Pethidine until the male nurse becomes available. I know that the patient will suffer for a long period before being given their I.M painkiller injections, but I cannot do it, even if I am alone and nobody is watching me. It is something from inside me, which prevents me from exposing patients' bodies even to give them an I.M injection."(S.N P(52); F; S.M; P.H)

Sexual surveillance also had an impact on the communication between nurses and patients of opposite gender:

"I think that all nurses should deal with all patients nicely, and with smiles in order to encourage patients to communicate their pain. However, the gender issue asserts itself strongly in our work. Although I encourage nice treatment of patients, I discourage female nurses from talking at length to male patients. I even discourage them from applying supporting touch to patients younger than seventy years old, because a patient might not accept such actions and might respond unexpectedly. Female nurses deal carefully with young patients and those who have undergone operations in genital areas... Some young patients might lie regarding their pain in order to attract a female nurse to his room to talk with her, or just to see her. This of course, limits nurses' communication with patients..." (H.N P(1); F; S.M; M.H)

"... I think that our traditions govern how female nurses communicate with male patients... Some male nurses, on the other hand, do not respect a female colleague who talks with patients informally. The talk that occurs between male nurses might dirty the reputation of a female nurse who did not do anything wrong apart from dealing informally with male patients. Most female nurses try to avoid this by keeping the communication with all males as formal as they can..." (H.N P(1); F; S.M; M.H)

Nurses also reported fears that their examinations of male patients may be misunderstood by members of the health care team and other workers in the hospital. This had a strong effect on keeping nurses away from even participating in the assessment of patients in the presence of male doctors. Nurses in both hospitals did not participate in the assessment of male

patients' incisions in the presence of the doctors because they feared this would be interpreted negatively:

"I do not do physical examinations of male patients because this is shameful, and it is not in our job description. If I did this thing, even hospital maids and other colleagues would talk badly about me." (S.N P(54); F; S.F; P.H)

"I avoid looking at a patient's incision when I am with a doctor during the doctors' round; if I do not I am afraid that doctors may misunderstand my work. If they saw a female nurse looking at a patient's exposed body, some doctors might dare and behave impolitely with her, because of their misunderstanding of the nature of her job... I said earlier that our culture focuses on one issue, which is (male-female contact). This issue hinders the entire nursing process, not only the pain management process." S.N P(3); F; S.M; M.H)

Fear of misinterpretation also affected the way in which female nurses built professional relationships with male colleagues. Given that all of the doctors in the studied surgical settings were males, and the majority of nurses were females (Chapter Three, Subsection 4.3.3), the male doctor-male nurse relations did not raise any issue related to sexual surveillance. However, sexual surveillance and much talk did take place when the relationship included a female nurse and a male doctor. Thus, relations between nurses and doctors or between nurses of opposite genders were mostly formal and brief in order to avoid misinterpretation:

"I am friendly with everybody, of course within a frame of polite behaviours, especially with female nurses, because our community does not have mercy upon any misunderstanding and does not tolerate the suggestion of any relationship with any of the female nurses" (D.R (67); M; P.H)

"Of course dealing with female nurses is different from dealing with male nurses. The relationship I have with female nurses is more formal. When work finishes I can talk freely with a male nurse, but I have no justification to talk with a female nurse. On the other hand, I can shout in the face of a male nurse, but I should be more formal

with female nurses.” (D.R P(43); M; M.H)

“My relationships with female nurses are usually a little better than those with male nurses because I feel that female nurses are more organized. However, I deal with female nurses within a frame of cultural traditions and customs. I am freer in my dealings with male nurses.” (D.R P(70); M; P.H)

The organizational sexual surveillance exercised by agents of the investigation agency also played a role in limiting the development of professional relationships. Restricting the building of relationships between professionals further hindered the passing on or discussion of information about patients’ pain conditions between professionals of opposite genders:

“The strict inspection of nurse-doctor relations is a hindering factor for accurate communication regarding patients’ complaints. For example, the female nurse avoids contacting a certain male doctor too frequently in order for her actions not to be misinterpreted. The agents of the military intelligence agency inspect any frequent contact between a certain female nurse and a certain male doctor. Sometimes, the nurse needs to talk with the doctor about a patient’s private affairs without being heard by others. This cannot be done in all military hospitals. We try to talk briefly to doctors; hence most of our patients’ complaints are missed.” (S.N P(6); F; S.M; M.H)

In this way, the culturally set boundaries between females and males had a disciplining role. Nurses and doctors learned how to interact with each other through the culturally set boundaries between males and females. Further, nurses learned how to deal with patients of the opposite gender, and adapted their practices to echo the cultural traditions, even if this meant that professional and organizational policies were ignored.

The issue of sexual surveillance and fear of misunderstanding and misinterpretation also influenced me as a female researcher. Although I

pressured myself to move between patients' rooms during the late night shifts, I did not feel as comfortable entering these rooms as I did during the day time. This was partly because of my fear of having my actions misunderstood by both nurses and patients, and partly because of my worry that people may be unwilling to cooperate with me if they felt I behaved differently to them and did not respect Jordanian traditions. However, this fear of misinterpretation was absent when I conducted observations in female patients' wards in both hospitals late at night.

1.1 Nurses' pain management practices with patients of the same gender

Paradoxically and unexpectedly, I noticed that some actions that were explained as a consequence of sexual surveillance and fear of misinterpretation were also applied by professionals where patients were of the same gender as carers and thus where sexual surveillance did not have any influence. For example, it was mentioned that some nurses withheld or delayed administering painkillers, or avoided assessing patients of opposite gender. Paradoxically, even nurses who worked with patients of the same gender showed a lack of pain assessment actions:

"I am not capable of deciding whether a patient is in pain or not. However, I can judge the patient's need for a painkiller from the time which has passed since the last injection was given to her... We have a bad assessment. While we are working or sitting in the head nurse's office, relatives of patients come and inform us that their patients are in pain. Immediately, we call the doctor and ask him what to do, or ask him to come and sign a narcotic prescription sheet. I know that we are supposed to assess the patient's pain first, but we do not..." (S.N P(21); F; S.F; M.H)

"Honestly, we do not assess patients for pain. I only judge if the patient is in pain or not from his facial expression, and relying on

my experience. I can also judge the best time to give him the prescribed painkillers. Some patients tolerate pain and they are discharged from the hospital without being given one dose of painkillers.” (S.N P(55); M; S.M; P.H)

Some nurses also avoided physical examination of patients’ incisions even though patients were of the same gender. These actions might be caused by the belief among nurses that patients’ physical examination is not within their remit:

“I do not do an assessment of pain or its origin. It is the doctors’ task to assess patients’ pain. However, I ask the patient about, for example, the origin of their pain... I have never done any physical examination of any patient whatever their complaint was. I did not do this even when I was in the male ward. This is not our job. It is the doctors’ job to assess patients and to do the physical examination. When a patient complains of pain, I just call the doctor.” (S.N P(22); F; S.F; M.H)

Other nurses explained their unwillingness to physically examine the incisions of patients of the same gender when they complain of pain by attributing it to their: ‘forgetting how to do it’:

Usually, I do not do a physical assessment of patients because I forgot how to do it. I think it is enough to look at the patient’s face to know if she is in pain or not.” S.N P(17); F; S.F; M.H)

In addition, some nurses did not apply pain management techniques which they had learned at the university with patients of the same gender. Nurses in the female wards did not apply pain management techniques, such as supportive touch or making jokes, even though all the nurses were female, and no male nurses were present:

“The most important thing we do is apply the doctor’s postoperative order of painkiller. We do not apply any of what we learned during our college study.” (S.N P(17); F; S.F; M.H)

So, in summary, the socio-cultural context imposed disciplinary power on participating individuals when they were involved in relations with others of opposite gender. However, this socio-cultural disciplinary effect does not seem able to explain nurses' similar practices when they deal with patients of the same gender.

In addition, the socio-cultural context seems to penetrate the organizational setting and appears to exert a greater influence over nurses' practices than the requirements of the organization. Although whenever power is present there are actions of resistance, under the influence of socio-cultural disciplinary power, nurses did not show the resistance that Foucault's theory suggests they might. Instead, nurses showed subordination and adapted to the power of the socio-cultural context which was dominant in wards where people of opposite genders were present. The nursing subordination to socio-cultural context appeared in their adaptation to the cultural traditions and in refusing to work with patients of opposite genders.

The next subsection will deal with the techniques that nurses adopted to avoid breaking the socio-cultural traditions through measures such as 'inappropriate delegation'.

1.2 Inappropriate delegation: Another form of nurses' subordination to socio-cultural context

Concerns about sexual surveillance encouraged a type of inappropriate delegation among nursing team members. Delegation is considered inappropriate where it is not distributed on the basis of the relative merit or qualifications. It was found that female staff nurses delegated tasks they

wished to avoid doing to male staff nurses in same or nearby wards, or to associate, or even practical nurses:

"If a male nurse is unavailable on the shift, for example, if they are having dinner, I ask for the help of male nurses from the nearby wards to give the patient his I.M injection." (S.N P(53); F; S.M; P.H)

"It is impossible for me to assess a male patient physically for his pain. I avoid doing ECG, or changing wound dressing. I always ask male nurses to carry out these tasks and also to administer I.M injections..." (S.N P(65); F; S.F; P.H)

"The brother of a colon cancer patient came to the nursing room and said to the S.N: 'Sister, my brother complains of pain'. The S.N withdrew 100mg of Pethidine and ordered the male A.N to administer the I.M injection." (Observation (3); S.M; M.H; Shift (C); 10:15pm)

The issue of delegating tasks to staff of insufficient qualifications is important to be examined because of the nature of preparation different nurses receive in their educational training, which might entitle some but not all to certain type of tasks. This issue sheds light also on nurses' practices of ignoring organizational policies requiring that only staff registered nurses administer medication. As a consequence, such delegation clearly increased the workload of male nurses whose number was small on each shift in comparison to the number of female nurses:

"The female S.N has drawn the Pethidine and asked the A.N to give the patient his injection. I asked the S.N, 'is there a policy that determines who should give the injections to patients?' S.N answered, 'Actually, only a staff nurse should give narcotic injections to patients. Not just narcotics, but all types of medication should be administered by a staff nurse. However, I am a female, and I feel embarrassed giving injections to male patients, because of cultural traditions.' The male A.N the work was delegated to said, 'We asked more than once for an increase in the number of male nurses on the male ward, but our request was refused... Here, female nurses do not work as much as we do with patients. Some female nurses avoid even measuring the blood pressure of patients.' (Observation (3); S.M; P.H; Shift (C); 10:55pm)

"This adds an additional load to the on-duty male nurse, especially if he is working alone with another two or three females... Can you imagine the weight of the load under which the male nurse works when he is alone with three female nurses and 42 patients?"(S.N P(8); M; S.M; M.H)

"... When I work with female nurses on the same shift, all of the workload is diverted onto me, because female nurses do not accept some of the tasks because of the cultural traditions..."(S.N P(56); M; S.M; P.H)

The increased workload of male nurses diverted their attention from patients' pain complaints to other matters (Chapter Six, Section Two, Subsections 1 & 5).

In summary, it was found that an interiorising fear of sexual surveillance, or the fear of having their actions misinterpreted, influenced nurses' practice. The fact that nurses gave up carrying out certain tasks because they were considered contrary to traditions is a serious issue due to the implications it has on nursing professionalism in both the hospitals studied (Chapter Seven, Subsection [II, 2.4]).

2. Influence of sexual surveillance on patient practices

Sexual surveillance also impacted on patients' postoperative pain practices. Under sexual surveillance that was mostly exercised aurally, female patients avoided voicing pain if males were present in their rooms, even if the curtains, which were placed between beds, were closed:

"... I cannot shout or call nurses in the presence of the male visitors of nearby patients, but I can do this in the presence of female visitors. For a while, I felt pain, and my fellow wife was not here; I wanted to call the nurses, but I could not because there were male visitors with the nearby patient. You know, the nearby patient is only less than two meters away from me. Thus, I cannot even talk or moan." (P.T F(P-6); S.F; M.H)

"The inability of our female patients to complain in front of male visitors of nearby patients is a problem that we face." (S.N P(22); F; S.F; M.H)

"The presence of many patients in a crowded room with many visitors prevents some female patients from expressing their pain, shouting, moaning, etc, because it brings shame..." (S.N P(54); F; S.F; P.H)

It was not only female patients whose expressions of pain were restricted by the presence of visitors of the opposite gender in their rooms, but also some male patients:

***Researcher:** May I ask you, what do you think about the ward structure?*

***Doctor:** I think that it affects a patient's willingness to communicate his pain when he is in the presence of female visitors and other patients, especially in crowded rooms. I witnessed some patients who underwent surgeries in the genital area that were shy of talking about their pain until after their relatives left their rooms." (D.R P(41); M; M.H)*

Similarly to female professionals, some female patients expressed a fear of having their actions misunderstood by the surrounding people when a professional of the opposite gender performed interventions such as touching, or even humour:

***Researcher:** How would you interpret a nurse's (of same gender) supportive humour or touch?*

***Patient:** This would decrease my pain.*

***Researcher:** How would you interpret a nurse's (of opposite gender) supportive humour or touch?*

***Patient:** I would refuse, since people surrounding us would misinterpret the intervention whether talking and laughing with a strange male, or being touched by him. It is shame." (P.T M(P-32); S.M; P.H)*

The socio-cultural boundaries also had a strong influence on relationships between professionals and patients of opposite genders:

"... Some of the teaching rounds include more than 15 medical students, and most of them are males. Most of the female patients refuse to be examined in front of them. I think that this is sometimes a barrier to the deepening of the relationship between me and my patients. Similarly, when the teaching round includes female medical students, female students avoid examining male patients." (D.R P(68); M; P.H)

"In addition, because of our traditions governing the relationship between males and females, I deal more carefully with a female patient. I cannot expose her body suddenly or assess her unless a female nurse or one of the patient's female relatives is present, which means that female patients cannot express their complaints to me privately, without the presence of a third party." (D.R P(36); M; M.H)

3. The extension of the patriarchal position of males into Jordanian hospitals

The patriarchal position of the male in the Jordanian family had explicitly reproduced itself in gender relations between professionals and patients in the studied hospitals. The influence of patriarchy was explicit, whether in patients' and professionals' actions, or preferences. Many female nurses reported an inability to become involved in pain assessment because of a fear that their husband or tribe may misinterpret their role:

"... When I deal with patients, I take into consideration that the patient, or persons around him, knows my family and me. If I were to take any action which could be misconstrued this might cause me big trouble with my family and with my husband. Sometimes, I avoid assessing a patient's wound because I expect that I will meet the patient during a familial occasion, which would be embarrassing..." (S.N P(3); F; S.M; M.H)

"Our culture also influences our work negatively... My husband does not like me working in the male ward; hence I cannot talk or deal freely with male patients, even if they are in pain. The view of my husband, community, and patients prevents me from behaving informally with patients. My husband's family always criticizes me for working in the male patients' ward...." (S.N P(11); F; S.M; M.H)

The effects of tribe and husband also influenced the preferences of female patients. For example, many patients said that they preferred being treated by female professionals to avoid provoking their husbands:

“Researcher: How would you interpret a nurse’s (of opposite gender) supportive humour or touch?

“Patient: No, I do not accept this treatment from any male nurse because I am married. If I am still single, I might accept this. My husband does not accept such treatments from males, and he might misconstrue this. It might lead to divorce.” (P.T F(P-29); S.F; P.H)

Consideration of their husbands’ attitudes had also influenced female patients’ willingness to express and complain about their pain. Some female patients and relatives said that complaining frequently about pain in front of a husband might make him search for another healthier and maybe younger wife. Thus, female patients reported that they wished to appear young and healthy by not complaining of any pain in their husbands’ presence. This was reinforced by their idea that some husbands might view women who complain as growing old and ill:

“Some husbands are uncooperative, or careless, hence, their wives avoid talking about their pain with them. Also, some men do not like seeing their wives complaining of pain. Some men think that ill women become old, and that if this happens they should search for another wife who is healthy and young. Usually, I do not complain in front of my husband in order to appear always strong in his eyes.”(F.Relative (P.T P(24); S.F; P.H)

“I think that women in Jordan are not always able to freely express their pain, this is because of the people who surround them, and the shame they are encouraged to feel. Some women do not like to talk about their pain because their husbands do not appreciate their pain, and they think that their wives are old.

Researcher (to the patient): what do you think?

“Patient: Yes I think this is right...” (F.Relative (P.T(P.28); S.F; P.H)

This attitude might explain why some female patients delay coming to

hospital despite experiencing pain.

Male professionals also extended their familial position as husbands, sons, or brothers to their relationships at work. Imposing power, by embodying the position of a husband, for example, explicitly impacted upon female patients' willingness to express pain:

"The doctor mocked and said, 'You have pain because you are fat. Your abdomen seems to be the abdomen of three women. If your abdomen was smaller, your pain would be less. If you were my wife, I would starve you until you were thinner'. All of the doctors who were accompanying this doctor laughed. I felt so embarrassed. Most of the doctors were young. Actually, this made me more hesitant to tell him about my pain." (P.T F(P-24); S.F; P.H)

When the female patients were older, male professionals used words such as 'mother' to communicate with them. Although calling older females 'mother' is an expression of respect in Jordanian society, it also indicates overtly that professionals viewed their relations within the hospital in terms of real familial positions:

"... When the doctor assessed me for the first time he called me 'mother'." (P.T F(P-26); S.F; P.H)

The brother's power and position in the Jordanian family is similar to that of the father and husband. In the majority of honour crimes in Jordan, the brother is the person who carries out the killing, even if he is younger than his sister. Because female and male professionals were mostly of similar ages, male professionals and even patients called female patients or professionals 'sister' to indicate that the relationship between them is respectful and does not include any restricted practices:

"As a man, I feel sorry for female patients when they complain of

pain. The male patient can tolerate pain, but female patients cannot. I feel they are like my sisters. They are weak and cannot shout all the time like male patients, since they are shy." (D.R P(37); M; M.H)

"... All female nurses in this place are like my sisters." (P.T M(P-17); S.M; M.H)

"I consider all female nurses as sisters, and I am a patient." (P.T M(P-31); S.M; P.H)

The internalization of their superior position seems to have influenced the willingness of some male patients to communicate pain. Some male patients were prompted to stoicism by the public view of masculinity, and the respected superior position of males in the Jordanian family. Some male patients said that complaining of pain was only for weak people, such as women, preferring to show masculinity through stoicism, especially if the health professional they were dealing with was female:

"...I think that the man should not cry, shout or complain frequently, because he is a man. My wife complains of the slightest pain, and I consider this a weakness." (P.T M(P-11); S.M; M.H)

"I tried to hide my pain. I asked others, who phoned me not to come because I was tired, and I wanted to take a rest. I avoided revealing my pain because, you know, it is shameful to complain like women in front of others." (P.T M(P-19); S.M; M.H)

"After five minutes, the same relative came to the head nurse's office and said, 'You did not give him a painkiller, he says he has pain'. The S.N (Participant 8) said, 'He is not in need of a painkiller, he welcomed us, and is sitting upright. Nothing indicates that he is in pain'. The relative said, 'he [the patient] is proud, he cannot cry to prove he has pain'."(Observation (17); S.M; M.H; Shift (B); 4:00pm)

"Most old patients prefer to complain to a male nurse because they believe that a man should not complain in front of a woman." (S.N P(8); M; S.M; M.H)

Other patients 'lied' about the extent of their pain, preferring to communicate it to male rather than female nurses:

"I witnessed many times that male patients, especially young patients, do not reveal their pain to female nurses. They always wait for male nurses to tell them about their pain, especially if the surgical incision is in a private area. Sometimes, male patients lie and fabricate another complaint when female nurses ask them, especially, as I told you before, if the incision is in a private area. I feel that my gender inhibits patients from talking to me, or from even telling me about their problems." (S.N P(52); F; S.M; P.H)

"A patient post haemorrhoidectomy is complaining of abdominal pain, febrile (39 c), said: 'I asked the female A.N, who administered intravascular fluid to me an hour previously to call one of the male nurses, saying: I have abdominal pain, would you call any of the guys?' Male S.N (Participant 8) later told me that 'the patient was complaining of pain at the site of his operation, not of abdominal pain. He was too shy to tell the female nurse about that. Hence he asked for any male nurse's help." (Observation (6); S.M; M.H; Shift (B); 7:10pm)

So, male patients tried to appear stoic because of pride, a concern with images of masculinity, and concern of public opinion. Stoicism was also practised by females because of shyness, and traditions that enhanced sexual surveillance, as well as because of fear of their husbands' view. However, professionals gave different reasons for the stoicism of both genders. Some professionals attributed the stoicism of male patients to a higher threshold of pain, revealing a gender-biased view by describing female patients as 'complainers' and 'nagging':

"Some patients tolerate the pain more than others. I think that the male patient has a higher pain threshold than the female patient. I know that from my experience and knowledge about male's body structure. The male's body is tougher and stronger. You rarely hear about females who tolerate pain more than males after the same type of operation."(D.R P(71); M; P.H)

"I think that the age and gender of patients influences pain

management. For example, young patients do not tolerate pain as well as the older patients do. Female patients have a lower pain threshold and so they keep nagging and complaining about their pain.”(D.R P(36); M; M.H)

Other professionals proposed a contradictory perspective, saying that the pain threshold among female patients is higher than among male patients for the same type of operation, and thus female patients do not express pain frequently:

“...Female patients do not complain most of the time because I am a male doctor and because the pain threshold is higher among female patients than among male patients. Thus, female patients tolerate pain more than male patients. The gender of patients slightly influences my treatment, but my treatment depends more on the type and site of the operation.”(D.R P(37); M; M.H)

“Yes. I noticed from my experience that female patients complain less about pain than men. I could conclude that the pain threshold among female patients is higher than that for men who have had the same type of operations. That is why they tolerate pain more than men. Hence I usually prescribe lower doses for female patients.” (D.R P(41); M; M.H)

Only a few professionals recognized that such stoicism may be influenced by the cultural view of the different genders:

“From my experience, I can say that the male patient is more capable of tolerating pain than the female patient, because he tries to appear strong.” (D.R P(68); M; P.H)

“I think that males in our society tolerate pain more than women, not because their pain threshold is higher, but because the society controls how the individual expresses his or her feelings.” (D.R P(69); M; P.H)

That those working with patients’ pain complaints relied entirely on terms such as ‘threshold’ and ‘tolerance’, indicates how pain is signified and separated from its social body. This means that female or male patients who hide their pain for social reasons might suffer silently without being treated

under professionals' assumptions that they have high pain thresholds. Even stoic patients might express pain, but the data revealed that such patients expressed severe and even agonizing pain using mild expressions that nurses and even doctors often disregarded. Some relatives said that their family members usually refrained from crying, shouting, or even talking about their pain in their day to day lives, but during their hospitalization they cried. Cases such as the following examples suggest that the pain patients feel is sometimes so severe that it pushes them to break their more typical stoicism, either by breathing deeply, crying, expressing it verbally or through facial expressions:

"My father does not reveal his pain to anybody, only if the pain would lead him to death... he does not show any sign of the presence of pain, only if the pain is very severe. I have always heard my father say that a military man must harden himself and should not be seen by others as weak. Military men should always appear strong and solid in front of all people, even those closest to him. A military man should help people, but should not wait for assistance from them. When his leg was broken, he did not utter a single word, but was simply breathing deeply." (M.Relative (P.T M(P-11); S.M; M.H)

"Usually, she does not complain of pain. Yesterday after the operation, I felt that she was hiding her pain, and suffering alone. I knew that from her facial expressions, although she said that she was not in pain." (F.Relative (P.T(P-26); S.F; P.H)

Due to a lack of preoperative assessment, nurses were unable to compare patients' status before and after the operation accurately. In addition, they were also unable to judge whether a patient who does not usually express suffering had pain or not due to a range of factors inhibiting expressing pain. The presence of relatives was an important factor in revealing the extent to which such patients were in pain. This is because relatives had a

knowledge of their family members, which nurses lacked due to an unfamiliarity with patients' attitudes.

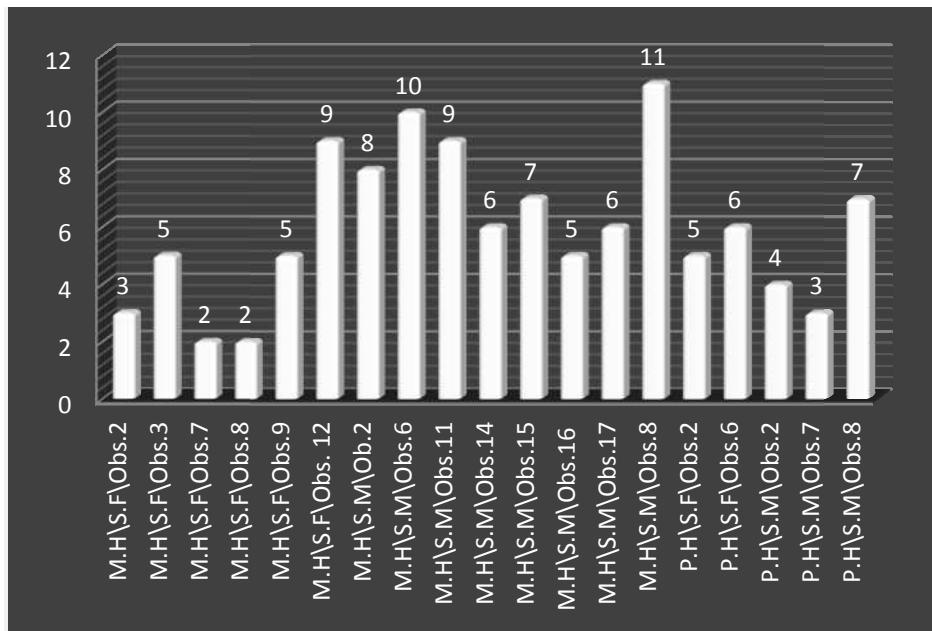
The next subsection will discuss the advantages and disadvantages of the presence of relatives in patients' rooms.

4. Social-familial traditions in supporting hospitalized surgical patients: Visitation

The previous section suggests that the dynamics relatives and visitors presented in wards with regards the sexual surveillance of patients and professionals can be usefully compared to Foucault's *panopticon*. It was shown that patients and nurses often felt restricted by the presence of relatives. This section will examine further the impact visitors had on the actions of professionals and patients, as well as the benefits of their presence.

In both hospitals studied visiting hours were open and long. Visitors could see patients at any time with little restrictions on their number. Figure (5) shows the mean number of visitors of each patient during different observation episodes in the surgical wards of both hospitals.

Figure (5): Mean number of patients' visitors during different observation episodes in both hospitals



The observations included in the above graph represent the available data regarding the number of visitors in the four surgical wards in both hospitals. The numbers of visitors were not counted when patients or relatives had closed curtains around the beds.

The numbers in Figure 5 reflect a Jordanian custom of visiting friends and relatives, especially at a time of crisis, such as illness, to express strong social ties and relationships (Chapter Two, Subsection 5.5). However, because this custom took place in hospitals, where professionals needed to work privately with patients, the high number of visitors often impacted upon professionals' work. Some professionals said that the large number of visitors threatened patients' privacy by placing them under direct observation, especially when curtains were not provided between beds:

"Yes, it has an effect since the visitors' view of nurses is bad. So, I feel uncomfortable. The large number of visitors hinders the privacy of patients."(S.N P(2); F; S.M; M.H)

"The large number of visitors breaks the privacy of patients, so we cannot work with patients efficiently..." (S.N P(13); F; S.M; M.H)

In addition to the sexual surveillance, which the presence of relatives reinforced, the large numbers of visitors hindered the privacy of nurses, especially female nurses, who said that they avoided working in patients' rooms in the presence of many male visitors because they felt that they were being monitored:

"The rooms are small and become overcrowded when there are visitors. Some scrutinize the nurses while they do their work. They think that we work in the wrong way." (S.N P(21); F; S.F; M.H)

"...I do not like working in the presence of visitors, especially men. I avoid entering crowded rooms frequently, even if there are 'fresh' surgical patients." (S.N P(63); F; S.F; P.H)

"...The large number of visitors around a patient hinders the nurses' movement in and out the room. Some visitors interfere with our work while we do something for the patient. In such cases, I delay doing any of the procedures until the visitors leave..." (S.N P(56); M; S.M; P.H)

The presence of visitors in large numbers and for long periods had further hindered professional-patient communication regarding patients' pain:

"The presence of visitors during the morning round is a real problem that impedes our work and honest discussion with patients, whether regarding their pain or other complaints." (D.R P(33); M; M.H)

"...The crowdedness of patients' rooms with visitors prevents nurses from communicating freely with patients or listening to their complaints." (H.N P(1); F; S.M; M.H)

"A doctor, Lieutenant colonel, entered a room of three beds (4m X 4m in area) including about 16 visitors excluding four patients. The doctor entered the room, and went directly to the patient's bed (52 years old, post operation of fixing fracture of the neck of the femur, and recent myocardial infarction). He assessed him in front of other patients and visitors. There are no blinds in this room between patients' beds. When the doctor finished, he just left the room with not one word to the patient or his relatives." (Observation (11); S.M;

M.H; Shift (B); 3:50pm)

Some nurses and patients revealed that visitors did not provide patients with psychological support. Instead, the presence of many visitors caused distress for patients:

"I think that the patients' visitors do not achieve their aim of supporting the patient psychologically. Instead, they talk about sad events around the patient, which lead him to be distressed." (S.N P(23); F; S.F; M.H)

"The large number of visitors, who do not support the patient psychologically, is really an impeding factor. Visitors mostly talk about death and examples of the critical health conditions of persons they know. I think that two visitors for each patient are enough..." (S.N P(4); F; S.M; M.H)

"... Although my visitors do not do anything to show their empathy, I appreciate their visit." (P.T M(P-10); S.M; M.H)

"Yesterday, when I had severe pain, I was distressed and annoyed by my visitors and the visitors of the nearby patient...the problem is that visitors talk about their own problems and matters...I felt their presence increased my distress and pain....of course I cannot ask them to leave because it is shameful to ask the visitors who travel long distances to leave." (Observation (4); S.M; M.H; Shift (B); 7:20pm)

However, the previously mentioned perspectives must also be counterbalanced with the psychological support and reassurance that visitors provide patients (Daly, 1999). "The gaze that is turned upon [patients] by those close to [them] has the vital force of benevolence and the discretion of hope," (Foucault, 1975: 46). Some patients said that the presence of their relatives enhanced their willingness to communicate their pain:

"She likes to express her pain in the presence of her sons and daughters. Otherwise, she keeps silent. I think she feels stronger when we surround her, and she relies on us to communicate her pain complaint to nurses." (F.Relative(4); S.F; M.H)

On the other hand, relatives were required to assist in patient care, in ways other than pure psychological support for a number of reasons. The poor communication between nurses and patients described earlier increased the importance of the role of relatives in passing patients' complaints to nurses, for example:

"Nurses are busy all the time, or maybe they forget what a patient asked them for because they are busy with others. I am the main link between nurses and my sister." (F.Relative(1); S.F; P.H)

Nurses indeed reported receiving more patient complaints of pain during visits by relatives and friends. This might be attributed to the fact that some patients stayed stoic until familiar persons, to whom they could express pain freely, became available:

"I, some times, think that the severity of a patient's operation does not deserve the amount they shout and cry, but our patients magnify their pain, especially in the presence of visitors... I noticed two things regarding the effect of the presence of visitors in the rooms of patients; firstly, some patients only start complaining of pain when their visitors come, hence, visitors start nagging and asking for painkillers... secondly, some patients, who are in the same room with a patient whose visitors are many, do not complain of pain or ask for painkillers until visitors of the nearby patient leave..." (S.N P(22); F; S.F; M.H)

"I witnessed that the patients' complaints of pain increase when visitors come. I do not know if this is a way of seeking sympathy from visitors, or whether it is an indicator of the distress that visitors cause." (S.N P(17); F; S.F; M.H)

The majority of relatives carried out some nursing tasks:

"I went to the nurses' room after an hour and asked them for a painkiller... The S.N gave me two tablets of Revanin [Paracetamol] and asked me to crush them and dissolve them in a cup of water and to give them to my father to drink." (Observation (16); M; S.M; M.H; Shift (C); 10:10pm)

"The relative is even more important than the nurse herself because the relative does everything for the patient. I feed her, change her

clothes, measure her temperature, change the bed sheets and carry the dirty ones to the laundry room, I even empty the urine bag. Recently, I learnt how to stop and open the I.V fluid when the I.V fluid bottle gets empty. In contrast, what do nurses do? They measure the blood pressure and administer medication. I mean they do routine work. I feel that we, as relatives, work more than we should tolerate. If nurses see me taking a nap, they start shouting, saying that I am not here to sleep.” (Observation (10); F; S.F; M.H; Shift (A); 2:00pm)

In conclusion, the presence of the relatives and visitors in the surgical departments of the studied hospitals had a dual effect, at times supportive and at times a hindrance. Visitors presence played a part in constituting a *panopticon*-like effect through which the actions of professionals and patients were monitored. This role often impeded the work of professionals as well as patients’ pain practices. On the other hand, for some patients, visitors provided a therapeutic gaze that helped patients feel supported in an unfamiliar place. In addition, relatives were often relied upon to assist with the practical care of patients.

5. The use of personal influence (*wasta*)

Wasta, refers to practices whereby the individual, or certain group of people, receive preferential treatment over others because of kinship, personal relationship, or shared benefit (Chapter Two, Subsection 5.6). Both patients and nurses said that the use of personal influence (*wasta*) had impacted on the pain management process, as well as other clinical processes. For example, many patients complained of the impact of the use of personal influence (*wasta*) on the quality of pain management presented to them. Some patients said that the use of personal influence (*wasta*) had elevated

the standards of the presented care for some patients but not for all. Thus, a feeling of inequality was captured in patients' interviews:

"My husband went to the nurses' rooms and asked them to give me anything to decrease my pain. My husband is a military man, and he was wearing his military uniform when he was here yesterday. After ten minutes of him arriving on the ward, I was given an injection of a painkiller... However, there is another patient in a nearby room, who kept shouting all night, and nobody cared about her shouting. I heard one of the nurses saying to her, "I will close the door of your room so that you can shout freely, you are not letting us or the other patients go to sleep." (P.T F(P-3); S.F; M.H)

"The doctor who performed my operation is my uncle in law. I felt that nurses were kinder to me than to other patients in the same room. Every time they came in the room, they asked me, "Are you a relative of Dr. X?" and they told me that he asked them to take care of me." (P.T F(P-29); S.F; P.H)

"If the patient is a relative of somebody in the hospital, he will be treated in a good way. I see some patients who do not know people working in the hospital, and I feel that they are not treated well. ..." (P.T M(P-38); S.M; P.H)

"When a recommended patient is admitted to the ward, although we do not give him more painkillers, we check him more often, and deal with him in a nicer way than with other patients..." (S.N P(60); F; S.M; P.H)

Professionals confirmed what patients said, revealing that the quality of care they provided to any patient they had a personal relationship or kinship with was higher:

"Some traditional rules govern how we deal with others. For example, I provide a better standard of care for patients who are my relatives, or those that I know, than that which I present to others." (S.N P(21); S.F; M.H)

"We are influenced by wasta. For example, if a patient is recommended, and has a written regular order of Pethidine, we apply the order as it is, and we give her the Pethidine regularly, but we do not do the same for patients without recommendation." (S.N P(63); F; S.F; P.H)

"Our culture also places a great influence on the way we deal with

and care for patients who have a high position or rank, or who know one of the persons in administration. For example, I try to be professional and to do everything correctly for the patients who I know. If any of his medications are unavailable, I try to secure them through personal relationships with colleague pharmacists. However, if any other patient's medication is unavailable, I do not tire myself to secure it.” (S.N P(4); F; S.M; M.H)

Discrimination in the quality of care presented to different patients seems to stem from social and cultural considerations, and a fear of familial and tribal blaming:

“...I make sure that the patient I know is satisfied completely so she will say good things about me in front of other tribe members when she leaves the hospital.” (S.N P(22); F; S.F; M.H)

“The Jordanian community is small and everybody knows everybody. Wasta plays an influential role in how we deal with patients. For example, if a friend asks me to care for his relative, I try to do my best in order to avoid future blame.” (D.R P(37); M; M.H)

“... This is how things go on. Otherwise, I might create a bad reputation for myself in front of my family or my friends.” (D.R P(69); M; P.H)

“Actually this is not because I like my relatives more than others, but because I know that my relative patient will leave the hospital and tell others about how I dealt with her or him. If I did not care about him or her as they expected, this will bring me a bad reputation in the family.” (S.N P(53); F; S.M; P.H)

As well as patients, the use of personal influence (*wasta*) affected professionals, who complained of its role in increasing their workload:

“Wasta... consumes the time of nurses as they care for recommended patients more than non-recommended patients.” (S.N P(24); F; S.F; M.H)

“Wasta is another cultural factor that influences pain management. Some doctors bring their relatives, friends, and maybe relatives of friends to the ward. They ask nurses to work with them, for example, to give medications, change wound dressing...etc. In this way, they waste the nurses' time and increase the load on them.” (S.N P(8); M; S.M; M.H)

The use of personal influence (*wasta*) had also impacted on intra-professional relationships and encouraged the feeling of inequality among them:

“S.N P(13): the most annoying thing in this hospital is wasta. Doctors can take training courses out of the hospital as much as they want. Nurses, who are not supported by important persons or people in the administration, are not informed about any available training courses. There is a clear inequality in the distribution of opportunities among different professionals...” (Observation (9); S.M; M.H; Shift (A); 2:00pm)

“Here, in the Ministry of Health and its hospitals, there are gangs, and lobbies. I mean that wasta and personal relationships play an important role in opening doors in front of some doctors and closing them in front of others.” (Observation (8); M.Dr; S.F; P.H; Shift (C); 2:30 am)

Both *wasta* and the feeling of inequality prompted opportunistic behaviours among professionals:

“Sometimes, some nurses deal in a nicer way with some patients... if this may later present a personal benefit for the nurse. Yes, Yes, this is present, and occurs often...” (H.N P(1); F; S.M; M.H)

“Sometimes, I work more with the patient who I can benefit from upon discharge. For example, if a patient or their son or brother works in a place I want something from; I provide a special and different care for him.” (S.N P(2); F; S.M; M.H)

Concluding remarks

Examples in this chapter have suggested that the socio-cultural context influences the practices of both patients and professionals in pain management. This was particularly noticeable where persons of different gender were operating in the same area. However, this context failed to explain the nurses actions with patients of similar gender. Nurses in both hospitals showed a complete awareness of, as well as subordination to, the effect of socio-cultural factors, and these factors seemed to have a greater

influence on the attitudes and practices of nurses than organizational policies. In their daily work nurses relied on socio-cultural traditions and norms rather than on a specific code of conduct, or organizational orders.

By restricting the extent to which they could engage directly with the bodies and care of patients, the socio-cultural contextual factors examined seemed to impact upon nurses' autonomy, knowledge, and practices, and consequently hindered nursing professionalism.

The next section presents findings regarding the influence of the organization on the practices of professionals, as well as its effect on nursing professionalism in pain management.

Section Two

The influence of the organization

Introduction

This chapter introduces findings about the effect the hospital has on the practices of professional staff working in it. It presents data on the techniques of disciplinary power that the organization imposes on professionals; its effect on inter- and intra-professional relationships; as well as its influence on nursing professionalism. Finally, it examines the influencing role some structural aspects of the organization have in constructing human behaviours.

1. Organizational disciplinary power: Displaying hierarchical observations

Both observations and interviews revealed an explicit use of disciplinary techniques to impose the power of the organization on its workers. Using the insights of Foucault, the power of the organization seemed to be exercised primarily through the disciplinary technique of ‘hierarchical observations’ (Foucault, 1977: 170).

Hierarchical observations in this instance took the form of inspection rounds that were carried out by medical and nursing administrators and supervisors, and people of high positions in the Ministry of Health, and military command.

Inspection rounds focused on reviewing patients’ charts, and other issues

related to the cleanliness and tidiness of wards, as nurses said:

"When inspectors come, they are usually of high rank and focus on records. They want to see that the vital signs sheet is filled out, nursing notes are completed... so I pressure nurses to write everything." (H.N P(1); F; S.M; M.H)

"...The managerial inspection rounds focus on files, the cleanliness of the ward, but not on the actual care presented to patients." (S.N P(63); F; S.F; P.H)

However, hierarchical observations were not always explicit. In both hospitals, a 'spying-like' surveillance was observed. I deliberately refer to it as 'spying-like' because participants could feel that surveillance was being carried out, but could not see it. In addition, participants felt suspicion, fear, power, and control over them as a result of this type of surveillance. In the military hospital, this type of surveillance was exercised by the hidden agents of the military investigation agency, while in the public hospital it was exercised by nurses, other workers, and even by patients' relatives. As nurses said:

"...There are lobbies and cliques surrounding the head of the department, who in turn has many spies to inform her about what is going on at all times and shifts." (S.N P(57); M; S.M; P.H)

"...Relatives work as spies. They are not spies literally, but when the relatives talk about what the nurse gave a patient it might harm the nurse, especially if the medication given was not prescribed by a doctor..." (S.N P(54); F; S.F; P.H)

A third type of hierarchical observation was that applied primarily by the head nurse of the public hospital through prompting individuals to monitor 'themselves':

"I deal with my nurses by developing self monitoring among them. For example, sometimes I randomly call some of the nurses, and I ask them an open and vague question such as, "Ok X, would you explain to me what I heard about you?" To answer this question,

they start admitting or justifying, or even accusing other staff who worked with them on the same shift. I make them feel that I am present at every moment. Some of them have told me that they dream of me. This is what I call self monitoring, it leads to the immediate and spontaneous correction of behaviours.” (H.N P(51); F; P.H)

The covert forms of surveillance had a greater psychological impact on nurses than the traditional overt inspection rounds. Covert surveillance was more obvious in the public hospital and more destructive because it was carried out primarily by members of nursing staff who worked on the same shifts and so damaged trust between members of the nursing team:

“S.N P(52): We are here under the inspection of spies. There is no trust among nurses, and between nurses and doctors...” (Observation (4); F; S.M; P.H; Shift (B); 6:30pm)

“Here one is continuously under the eye of spies who look for faults... do you know? I trust only a few nurses because some nurses are spies of the head nurse, and the head of the department. I only do my job. I do not even give a Paracetamol tablet to a complaining patient without it being prescribed by the doctor. This is because spies will, for sure, inform the head of nurses the next morning, and I will get into real trouble with her...” (Observation (6); M; S.M; P.H; Shift (B); 7:15pm)

Thus nurses could not avoid hierarchical surveillance, and in response developed a self-surveillance that regulated the way they acted either because of a fear of ‘spies’ or because of fear of punishment or both. The quotations above indicate that this self-surveillance was often detrimental to other professional relationships. It also profoundly hindered pain management by blocking nurses’ intentions to help patients in pain, even preventing them from administering weak painkillers such as Paracetamol:

“There are many other factors that are detrimental to our work, such as spying. For example, although Revanin is a safe painkiller, I cannot administer it to any patient without a written doctor’s order, because I have fears that one of my colleagues on the shift, and even

maybe one of the relatives, might tell the head of the department the next day. Sometimes, I am surprised when the head of the department tells me what I did on a previous shift. I feel that she was around, or she was in the pocket of my lab coat. Her spies are many and they tell her about everything in detail.” (S.N P(63); F; S.F; P.H)

“Presence of spies: most spies are those of long experience, and those whose relationships with people in administration is good. These spies are believed whatever they say to the head of the department or head of nursing. It happens frequently that a nurse refuses to give a patient Paracetamol, although it is safe, because he is afraid that his colleague will tell the head of the department next day.” (S.N P(56); M; S.M; P.H)

Because “trust is a key by-product of the cooperative social norms [sic] and [individuals]” (Fukuyama, 1999: 49), it seems that the lack of trust between staff members also affected cooperation between them. Nurses listed this as a factor impeding effective pain management:

“The quality of the nurses working with me on each shift... for example, the less trusted and cooperative the nurses I am working with, the more workload and wasted time there will be...” (S.N P(52); F; S.M; P.H)

2. Organizational disciplinary power: Fear of punishment

Hierarchical observations, whether overt or covert, created penalties that aimed to develop professional behaviours and practices which satisfied the expectations of the organization or inspectors. Failure to meet the expectations of inspectors often led to penalties, which prompted nurses to develop the desired behaviours. Fear of penalties also affected professionals’ actions further, by diverting their attention from patient-centred care to focus on fulfilment of the profiles which inspectors reviewed at the time of inspection rounds:

"The unexpected and even the expected inspections are very stressful. Inspectors check if the ward is clean or not; if the nursing notes are written or not; if the vital sign sheet is filled out for all patients or not; if waste is separated properly or not; if the top of I.V.F sets are covered or not; if and if and if. It is a long list of "ifs" in which the patient and his pain is not present. Inspectors push nurses to care about the surroundings of the patient more than caring about the patient herself." (S.N P(23); F; S.F; M.H)

"On the other hand, I feel that I work on the patients' medical files more than I work with patients themselves. I attribute this to fear of inspection episodes, which focus on filling all check-lists and sheets." (S.N P(8); M; S.M; M.H)

Nurses had developed protective actions to shield them from punishment. Because inspectors, whether managers, pharmacists, or heads of department, often focused on whether nurses filled out the patients' charts such as narcotics related papers, some nurses had fears of filling out the narcotic related documents at all. Thus, some nurses deliberately delayed or decreased the times they administered painkillers, even if it was written that they should be given on a regular basis, leaving patients in pain:

"...Many nurses do not give Pethidine at all to patients when they are on duty on any shift. They have fears of making mistakes during filling out Pethidine prescriptions or other related sheets...Yes, this is because of policies of punishment of any mistake in documenting narcotic administration. The documentation process of the narcotics administration is long and stressful." (S.N P(60); F; S.M; P.H)

In addition to delaying administering the prescribed narcotics or withholding them entirely, fear of penalties prompted some nurses to take short cuts by administering non-prescribed painkillers that do not require the completion of long documentation, instead of those that were prescribed, even if they were less effective at reducing patients' pain:

"Nurses in general prefer giving Voltaren (Diclofenac Sodium) rather than Pethidine because of the long and strict steps that

should be considered when administering Pethidine. For example, when administering Pethidine, the nurse should fill out a prescription sheet which includes the patient's name, age, his national number, home address, telephone and mobile number, military number, and finally they must call the doctor to sign it before administering the Pethidine injection. All of these should be recorded accurately and faultlessly. Thus, our nurses prefer administering Voltaren more than Pethidine to patients, although Pethidine might be more effective postoperatively.” (H.N P(1); F; S.M; M.H)

In addition, the long documentation process required when using narcotics often prolonged patients’ feelings of pain because it impeded immediate intervention by nurses:

“I think that some general policies that aim to control dealing with narcotics, are annoying, although they also aim to avoid addiction. Such policies are the long documentation process required before drawing any Pethidine injection, which sometimes inhibits some nurses from acting immediately with patients in pain.” (D.R P(70); M; P.H)

3. Role of organization in reinforcing nursing subordination

The disciplining instruments, hierarchical observation and normalization by punishment, reinforced the domination of doctors over nurses in two ways. First, most of the people who carried out inspections were doctors. Second, inspections and punishments were usually directed at nurses but not doctors.

As nurses said:

“The organizational system influences nurses' work and satisfaction negatively because of the absence of a reward process, and the punishment system. Inspection rounds focus on the work of nurses but not on the work of doctors. Also, the good and creative nurse is not rewarded, hence, their productivity and commitment does not improve. Here, everybody is treated similarly, whether they are creative or not.” (H.N P(51); F; P.H)

Nurses said also that doctors sidelined their knowledge and skills (Chapter

Five, Section Two, Subsection 1), as did the administration. Many nurses said that the administration sidelined nurses and supported doctors in any conflict, further reinforcing the subordination of nurses:

"S.N: As my colleague told you, the relationship stays good until a conflict takes place; at this point, everybody, such as the nursing administration, the head of the department, the manager of the hospital, and even some other nurses support the doctor. That is why doctors have more power over nurses..." (Observation (3); F; S.M; P.H; Shift (C); 11:00pm)

"... at the end, everybody supported the doctor against me, even the nursing manager. Since then, all the doctors hate me. I think that doctors support each other when one of their colleagues has a problem, but this does not happen in the nursing community." (S.N P(63); F; S.M; P.H)

"S.N P(3): 'I often asked him to serve himself. The doctor considered this disobedience, even though I am of a higher rank than him. He complained to the manager of the hospital. Unfortunately, the manager of the hospital asked for me, and I was ordered not to cross limits with the doctor, and to do whatever the doctor asks'." (Observation (9); F; S.M; M.H; Shift (A); 1:30pm)

The administrative support of doctors had also reinforced the inferior public view of nursing in two ways. The following example shows one way that people in administration treated nurses in the presence of patients. This made nurses feel that they were 'nothing' and fear that they were vulnerable to bad treatment from patients who saw the way they were treated by their administrators:

"Many factors affect nurses' work, and consequently influence pain management. Firstly, the way inspectors and people in command deal with nurses in front of patients. Sometimes, for example, the head nurse shouts in my face in front of patients, hence, I feel embarrassed and avoid entering their rooms. In these cases, I feel I am nothing and so I do not work properly with patients. This style of the treatment between persons in command and nurses establishes a bad view of nurses, and patients start to deal in the same way with nurses..." (S.N P(24); F; S.F; M.H)

Second, the limited authority of nurses meant they could not take immediate actions, which had a knock on effect on patients' estimation of nurses, reflected in patients' treatment and expressed views of nurses:

"We have a poor image because we do not have wide authority. Patients trust doctors more because they can take actions, but we only apply what doctors prescribe and order. I think that policies that limit the authority of nurses encourage and create such a poor image of nurses in society." S.N P(56); M; S.M; P.H)

The second factor mentioned above was reflected in many patients' actions and sayings. Some patients avoided communicating their pain to nurses because they believed that nurses had limited authority in comparison to the wide authority that doctors had. Patients expressed the belief that nurses had no power to make changes to their pain condition:

"I do not talk to nurses because I feel it is enough to talk to my doctor. Nurses only apply doctor's orders, and they have no authority to do anything without a doctor's order." (P.T M(P-11); S.M; M.H)

The lack of support that nurses received from their administration seems to have reinforced the inferior public view of them. Some nurses said that they are not well supported by the general administration or even the nursing administration if they were in conflict with patients or their relatives:

"... We are exposed to martial court each time a patient or relative complains to the manager, although patients and their relatives are not always honest." (S.N P(24); F; S.F; M.H)

"Nurses are also less powerful than patients. In more than one situation, patients complained to the manager who, in his turn, believed them without even listening to me." (Observation (9); F; S.M; M.H; Shift (A); 1:35pm)

"Our nursing administration is a burden on nurses more than a help. Our nursing administration does not support nurses at all. This, of course, depresses nurses, especially as they need somebody to support them in their conflicts with doctors and patients. However,

doctors and patients are always right; nurses are always blamed for any mistake, even if it is not their mistake.” (S.N P(3); F; S.M; M.H)

The head nurse of the public hospital confirmed nurses’ complaints about being unsupported by their administration, adding that subordination of nursing is necessary for the benefit of patients:

“If I receive any complaint from any patient about my nurses, I do not believe the nurse, and I punish them, even if I know that the patient is lying. I always tell my nurses that they should be subordinate to patients in order for them to feel their suffering, and to present humane services.” (H.N P(51); F; P.H)

So, organizational policies, whether embodied in hierarchical observation, or normalization by punishing or limiting nurses’ authorities, had decreased nurses’ autonomy and impacted on the public view of their ability to care for patients. It had also reinforced their subordinate position in the nurse-doctor relationship, and seems, consequently, to have contributed to further nurses’ reliance on doctors’ orders to initiate care for patients.

4. Role of organization in marginalizing pain management from staff’s work

The findings showed that both studied hospitals had marginalized pain management from the list of priorities by not applying pain management protocols and guidelines in surgical departments. As Fielding (1994) suggested, the absence of a clear assessment protocol for patients in pain reduces nurses’ and physicians’ commitment to the assessment of, and intervention with, patients’ pain. In this study, the absence of a protocol to standardize the work of those staff dealing with patients in pain obviously led professionals to apply interventions in line with their own, subjective, convictions:

"... One of the most important factors that hinders the successful application of pain management is the absence of a clear pain management protocol. Here, each individual treats it according to his own opinion and mood...Thus, pain becomes unobservable, and consequently unimportant and uncritical. The presence of a clear protocol would shed light on patients' pain whatever the pain severity is." (D.R P(41); M; M.H)

***"Researcher:** Do you think there are any organizational factors that might influence the pain management process postoperatively?*

***Doctor:** The absence of pain management policies that regulate the process and clarify, for example: who should be responsible for pain management at a certain stage, the type of analgesia used, and the frequency and method of pain assessment... I am not satisfied with the pain management applied in our hospitals. There is no recognized pain management protocol, and pain is managed according to what we are used to doing, not according to an updated protocol." (D.R P(39); M; M.H)*

Hospitals also hampered pain management by not setting a clear care delivery system. Observations and interviews showed that the delivery care system in both hospitals had a partial, but significant, role in fragmenting patients' bodies to a set of tasks. This, in turn, seemed to marginalize holistic care and ignored patients' subjective complaints:

"...We work according to the functional care delivery system, which does not care about details and less important complaints like pain complaints." (S.N P(52); F; S.M; P.H)

"We apply the 'semi-primary care system' on shift (A)...one S.N looks after the patients of one side [several rooms on the same side of the ward], which might include up to 14 patients. I mean that the S.N in this case is responsible for finishing all care tasks in help with the available A.Ns. During other shifts (B , C), we work according to the 'functional care system': one nurse prepares medications for all patients, the another prepares blood sample tubes to be drawn in the morning, another might administer I.V fluids to all patients on the ward. This is because fewer staff nurses are on-duty during shifts B and C. Hence, applying the 'primary care system' is impossible." (Observation (4); M; S.M; M.H; Shift (B); 6:20pm)

So, hospitals did not provide any guidelines or protocols for professionals to follow when dealing with patients in pain. This reinforced the feeling that pain was not a priority.

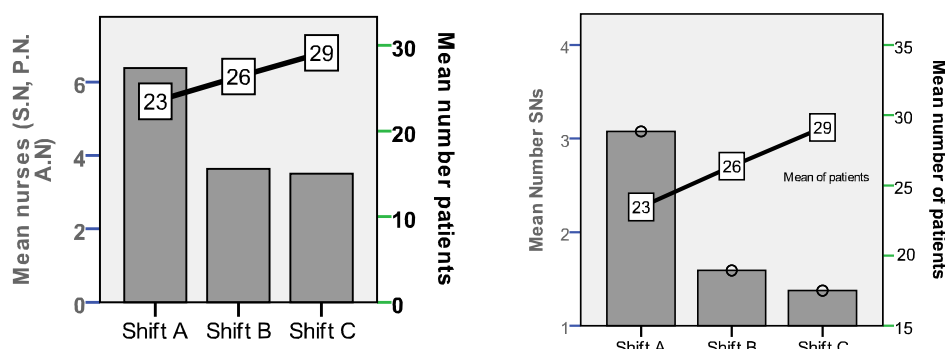
5. Staffing levels, workload, and the shifts schedule

The small number of nurses in comparison to the numbers of patients on surgical wards presented another problem at both hospitals. Observations and interviews (Table 9) showed examples of nurse to patient ratios as low as only two Staff Nurses responsible for providing care to 26 patients. Including Practical nurses and Associate nurses, this ratio still only rose to 4 nurses to 26 patients. Officially, there is nothing that determines the acceptable nurse-patients ratio in either of the studied hospitals.

Table (9):Mean of nurses' numbers to patients on different shifts	
S.N	2.00
(AN_PN)	2.44
S.N, P.N, A.N	4.44
Patients	26.00

The data also showed that the lowest mean total of nurses of all grades was noticed on shift (C) in both hospitals, when the number of patients on this shift was the same or slightly higher than on other shifts (Figure 6).

Figure (6): Mean number of patients and nurses on different shifts



Doctors and nurses commented that the workload and low staffing level diverted attention away from assessing and working with patients' pain complaints:

"...31 patients are cared for by one staff nurse and two A.Ns. The large number of patients prevents nurses from listening to and acting upon patient complaints. We are busy applying more important tasks than pain management or listening to patients." (S.N P(24); F; S.F; M.H)

"This ward is always full of patients. Because of the low number of staff nurses on each shift, pain is not a priority in our work. Sometimes one or two staff nurses and two A.Ns work with 42 patients...." (S.N P(3); F; S.M; M.H)

"I think that the workload is high; that is why I do not care about pain complaints when I check about 50 patients during the morning round. If I am busy, I ignore patients' pain complaints, and I even do not prescribe painkillers for them..." (D.R P(33); M; M.H)

The nature of the shift system was another factor doctors highlighted as hindering pain management, especially in the military hospital. Shifts limited the ability of doctors to follow patients during different days of hospitalization:

"I cannot follow patients all the way through their hospitalization period. For example, suppose that a patient told me he has pain today; I will not be able to follow him and reassess his pain condition the next day since another doctor will come and check

him tomorrow. Today, I check in-patients in the wards, but tomorrow, for example, I have to work in the out patients' clinic. Another doctor is responsible for checking in-patients." (D.R P(33); M; M.H)

Patients and visitors could see this:

"Every day, a different doctor comes to check the patient. Until now, I told most of them about ulcers in my father's back, but it seems that each one forgets what the patient says. It seems that they do not tell each other about patients' cases..." (Observation (5); M.Relative; S.M; M.H; Shift (A); 12:45pm)

6. The effect of social hierarchies

Professionals' social status had an influence on others' perceptions and actions. In both hospitals, it was noticed that patients' and even professionals' actions were modified by the effect of professionals' rank, military suit, or uniform.

When questioned about the effect of a professionals rank on their willingness to communicate postoperative pain, some patients said that they do not know enough about rank for it to influence their actions:

"I do not know anything about ranks. When I feel pain, I inform anybody in the room, and ask my daughter to ask nurses for a painkiller, or to do something to decrease my pain." (P.T F(P-1); S.F; M.H)

Even among patients who did not differentiate between rank, some preferred to communicate their pain to doctors rather than nurses:

"Although my husband is a military man, I do not have a good understanding about military ranks, but I trust doctors more than nurses because doctors are more informed about my case." (P.T F(P-3); S.F; M.H)

Other patients had a very different perspective on the rank of professionals which influenced their decisions about whom to communicate their pain to.

Most patients preferred communicating pain to professionals of high rank.

Patients attributed such trust in those of higher rank to more experience and better authority:

***“Patient:** Actually, I trust nurses of high ranks because they are more patient and have more experience.*

***Researcher:** Do you feel the rank of a doctor or a nurse influences your willingness to communicate your pain to them?*

***Patient:** As I said, I feel that my complaint will not be missed if I express it to a nurse of a high rank, since she will be more responsible and can intervene relying on her long experience.” (P.T F(P-4); S.F; M.H)*

“When a group of nurses come in the room, I look for nurses of the highest rank and talk to them, since I expect that their response to my complaints will be immediate because they will intervene, relying on their long experience and authority over other nurses.” (P.T F(P-6); S.F; M.H)

There were some patients - especially those who served in the military, and were of low rank themselves - who preferred communicating their pain to professionals of low rank, and some considered complaining to professionals of high rank shameful as it showed a lack of respect for their rank:

“I deal more freely with doctors of low ranks, maybe because I have a low rank in my job. Doctors of low rank are nicer than those of high rank, maybe because I am a soldier of a low rank... Mostly, I prefer talking to doctors of low ranks.” (P.T M(P-12); S.M; M.H)

“I think that my military traditions affect my relationship with them because I retired from the army many years ago [with low rank] ... I know that people of high ranks should be respected. This actually makes complaining to doctors and nurses of high rank more difficult. It is shameful to complain to professionals of high rank; it is really shameful.” (P.T M(P-16); S.M; M.H)

Professionals were aware of the effect of rank on the willingness of patients to communicate their pain, and said that relying on rank to determine expertise was mostly inaccurate:

"Most of our patients are soldiers, or relatives of soldiers. Soldiers, or military patients used to respect and fear persons of high rank in their job. Thus, you see them respect and fear doctors of high rank in hospitals also ... Military patients mostly complain about their pain to doctors of similar ranks. I have witnessed that some patients like talking to doctors of low ranks..." (D.R P(37); M; M.H)

Because of the estimated influence of rank on patients' willingness to communicate their pain to professionals, some professionals stressed the necessity of hiding rank when working with patients:

"I think it might help if doctors hide their rank when they check patients. There is a policy, which is not applied, in military hospitals, which decrees that the doctor should wear a white lab-coat over his military suit when he assesses or sits with patients." (D.R P(33); M; M.H)

In the public hospitals, professionals had no ranks. Some professionals wore a white laboratory coat over their own clothes. In general, neither nurses, nor doctors adhered to a clear uniform code. All observations in the public hospital showed that the majority of doctors did not wear a certain uniform, or even a name tag to refer to their identity:

"8:15 am: one of the morning doctor rounds has just started. It included one senior specialist, a specialist, and a resident doctor. Doctors wear their own clothes without lab coats or name tags." (Observation (1); S.F; P.H; Shift (A); 8:15am)

Even nurses, mainly male nurses, did not wear anything to show their identity on the ward. They usually wore their own clothes, and some wore a lab coat over the top. The situation was relatively different in the female wards because they adhered to a certain uniform.

Thus, some patients in the surgical male ward of the public hospital did not know to whom they should communicate their pain, especially when dealing with male professionals, taking for granted that female professionals were nurses. Many patients were not able to tell whether the male person working with them was a doctor or a nurse:

“Some patients do not differentiate if we are nurses or doctors. All of them call us ‘doctor’. When patients discover that we are nurses, their view of us changes and the way they deal with us also changes.” (Observation (2); M S.N; S.M; P.H; Shift (B); 4:00pm)

Doctors’ and nurses’ appearance, i.e. rank, dress and gender, thus influenced the willingness of patients to communicate their pain.

7. Influence of the structural layout of the ward

The structural layout of the ward had an effect on the pain management process through the way it influenced nurses’ behaviours. Nurses and doctors commented that the structural layout enhanced public *gaze* as most patients’ rooms lacked curtains and often became crowded with beds and relatives:

“...Patients’ rooms are small. Can you imagine the situation, especially when there is a large number of visitors? On the one hand, some nurses avoid working in these rooms. On the other hand, patients in pain cannot complain of pain because of a lack of privacy.” (S.N P(24); F; S.F; M.H)

“... Although patients’ rooms are big, they are crowded with patients’ beds and visitors. Hence, we cannot work freely with patients all the times.” (S.N P(65); F; S.F; P.H)

The structural layout of the wards, especially in the military hospital, impeded nurses’ willingness to assess patients who were in rooms further away from the nursing gathering area (Appendix Nine A, B):

"The corridor of the ward is long and some rooms are distant from my office which is at the beginning of the corridor. I have noticed that my nurses go to those rooms less often than other rooms. This problem, in the first place, is detrimental to patients who are not accompanied by relatives, or are immobile.." (H.N P(16); F; S.F; M.H)

"Yes. Some rooms are far from the nurses' room. Thus, some patients, especially those without accompanying relatives keep suffering until a nurse goes there by chance." (S.N P(8); M; S.M; M.H)

This problem was further complicated by the fact that there were no calling bells in rooms, whether distant or close:

"Some rooms are distant from the office where we gather ... The absence of calling bells in patients' rooms makes it difficult for some immobile patients, or patients without relatives, to inform us about their complaints." (S.N P(21); F; S.F; M.H)

Thus, as mentioned before, a main way by which nurses knew of patients' pain was through their relatives and visitors. In other instances, nurses knew about patients' pain when they did routine task rounds, or 'by chance':

"The head nurse's room is distant from patients' rooms. Thus, patients who are placed in far rooms, and do not have accompanying relatives, are neglected. They might keep suffering until we go to their room for a routine medications administration, for example." (S.N P(23); F; S.F; M.H)

Thus the structural layout of hospitals is seen to have an influence on how nurses behave, particularly in regard to patients situated in distant rooms. The structural layout reduced the ease with which patients could express pain complaints to nurses, especially in light of the lack of nursing assessment and check up practices.

Concluding remarks

This chapter showed that hospitals are more than a collection of structural units and factors. Hospitals as organizations are shown to have an effect on

practices and behaviours, both structurally through staff shortages and physical layout, and through the actions of those inside it, including the dominant discourses that displayed its effect in spaces of hospitals. The existence and operation of various influences were illustrated. These included, on the one hand, the disciplinary techniques such as hierarchical observations, and normalization through punishment; in addition to the display of power through professionals' dress or rank.

This chapter and the previous two chapters establish that the manner in which nurses work, especially with regard to pain management, is dictated in part by organizational factors, but is most significantly influenced by socio-cultural factors. This leaves little space for professional autonomy, or professional self-regulation.

Next chapter discusses these themes, linking them to the literature and the underpinning theory.

Discussion and conclusion

Introduction

This chapter discusses the key themes of the findings that emerged and links them to the underpinning theory and context of the related literature. The discussion is organized according to theoretically driven themes rather than research questions to attempt to limit the amount of duplication which would have arisen from dividing sections according to the interrelated research questions.

This chapter also outlines the original contributions of this study, and explores the limitations of the work. Conclusions and recommendations are presented at the end.

The research questions that guided data collection and analysis were:

1. What do nurses do to assess, manage, and document patients' postoperative pain?
2. What factors influence nurses' assessment, intervention, and documentation practices in postoperative pain management?
3. What factors influence patients' practices in the postoperative pain management process?
4. What are the influences of the Jordanian context on postoperative pain management?
5. What is the influence of the organizational context on pain management?

I. Nurses and patients' practices in pain management postoperatively

1. Nurses' practices

Findings from the two hospitals studied suggest that nursing pain management practices, whether assessment, intervention, or documentation, were lacking.

The findings suggest that nurses usually did not assess patients' pain, whether using a formal assessment tool, or by asking specific questions. When assessing post operative pain nurses usually relied on their common sense, or behavioural or physiological indicators such as vital signs and facial expressions (Chapter Five, Section Two, Subsection 1). In a few cases, to assess pain, nurses asked broad, vague questions that did not help patients to give precise answer about pain, such as 'How are you today?' and often did not take any subsequent actions if the patient complained of pain (Chapter Five, Section Two, Subsection One). This supports the similar findings of other studies, such as Shugarman *et al.*, (2010: Abstract), which also found that staff used informal pain assessment rather than scales such as NRS. Shugarman *et al.*, (2010) and Kappesser, Williams, & Prkachin (2006) concluded that when pain was not assessed using a formal pain scale, nurses underestimated pain intensity, especially among patients who did not usually express their pain or communicate it. Thus it seems likely that in the current study, because pain was not consistently assessed, it may have been underestimated by nurses.

When doctors assessed patients' incisions in their presence, nurses, especially female nurses, avoided looking at male patients' bodies, and in many instances they left the room. During night shifts, especially from 11pm to 5am, in both the male and female patient wards, nurses often did not check patients for pain or other needs.

Findings also suggested a profound lack of interventions to manage patients' pain. As revealed from nursing perspective (interviews and observations), nurses relied heavily on doctors to initiate patient pain care through writing orders for analgesics. No immediate action was taken by nurses when patients complained of pain, except for administering previously prescribed painkillers, or calling doctors to come and assess a patient's condition and decide whether to prescribe a painkiller. In addition, nurses reported that they delayed giving prescribed painkillers; often administered regular painkillers as PRN (*Pro Re Nata: as needed*); frightened patients about the potential side effects of and addiction to painkilling drugs; deceived patients by giving them water or antihistamine injections; told patients that experiencing pain is normal postoperatively; asked patients to sleep or do other activities, such as walking to decrease pain without painkillers; and demonstrated a lack of pre- and postoperative patient education practices regarding pain (Chapter Five, Section Two, Subsections 2 & 3).

Documentation of patient pain status or practices related to patient pain, except confirmation of the administering of prescribed narcotics, was not found in patient profiles in either hospital (Chapter Five, Section One,

Subsection 2). This observation supports other research findings such as Idvall & Ehrenberg (2002), Dalton *et al.* (2001), and Briggs and Dean (1998). The failure to document actions and issues related to patient pain meant that related information was often not passed between nurses and doctors, or between nurses on different shifts. The situation was made worse by a lack of verbal discussion of patients' pain conditions between staff of different shifts during clinical rounds (Chapter Seven).

The absence of pain documentation, especially in light of the lack of related staff discussion, is a potentially serious issue because some nurses administered non-prescribed painkillers to patients, but did not document this, fearing punishment for acting against official policy, which states painkillers should only be administered on a doctor's order. Such actions would expose patients to the danger of drug overdose as subsequent doses may be given by different nurses on the same or different shifts, unaware of what had already been administered.

From the perspectives of patients and relatives, nurses carried out a routine, task-oriented job, which only included changing dressings, measuring vital signs, administering medication, and withdrawing blood specimens. For the majority of patients, nurses' practices were unsatisfactory. Patients and relatives expressed this dissatisfaction, and their need for a greater level of help and care, by questioning nursing tasks, describing nurses using negative words such as 'hard-hearted', 'careless', or 'arrogant', and even, in some exceptional cases, attempting physical violence against nurses. In both hospitals, no patients and relatives gave clear 'good' descriptions of nurses.

2. Patients' practices

Patients' postoperative practices were varied. Some patients cried, screamed, shouted or frequently went to the nursing station to ask for help or information regarding their pain. Some kept stoic, or expressed pain through facial expressions. Some patients took their own painkillers that had not been prescribed by doctors and brought secretly from outside the hospital, or borrowed from patients in neighbouring beds (Chapter Five, Section Two, Subsection 3).

The following subsections address the issues that influenced nursing and patients' practices in the studied hospitals.

II. Nursing practices: A poststructuralist reading of nursing pain practices in the studied hospitals

A key theme emerging from the data is the lack of postoperative pain assessment, intervention and documentation practices; as well as the lack of nurses' engagement in the pain management process.

The findings show that nurses often relied on observation only, and did not move beyond this to the analysis of such observations, and the subsequent making of decisions, or determination of suitable intervention and evaluation. Engagement in patient care and assessment of clinical symptoms such as pain, can be seen to occur in two alternate stages of observation and 'spoken language' (Foucault, 1975: 137), leading to analysis and decision making. In other words, health professionals first inspect a patient for signs, listen and palpate. When a patient is suffering from pain, for example,

language becomes essential to assess their subjective experience (Foucault, 1975).

In the course of my research it became evident that nurses stopped after the first stage of observation, then no further involvement with assessing patients' pain occurred, and they only carried out doctors' orders. The findings also showed that nurses often relied on patients' behavioural indicators, and less often on physiological indicators to assess postoperative pain, ignoring patients' self-reports, which are traditionally considered the 'gold standard' for pain assessment (Chapter One, Section Two, Subsection 2.1). This supports the observations of other studies, such as Kaki *et al.* (2009); Horbury *et al.*, (2005); Kim, Schwartz-Barcott, Tracy, Fortin, & Sjostrom (2005); and Sjostrom, *et al.* (1997), which also found that nurses often relied on behavioural and physiological indicators to assess pain. This makes the observation that nurses employ very different from the *gaze* that doctors usually practice in their work. Thus, although both doctors and nurses relied mainly on objective behavioural and physiological indicators in their work with patients' pain, the *gaze* that doctors exercised seemed to produce power, authority, and public satisfaction because it was 'analytic' (Foucault, 1975: 133). However, the observing practice that nurses performed did not. This is because nurses exercised 'seeing', but did not exercise 'knowing' (Foucault, 1975: 131), and, as May (1995) has argued, this reduced the power and authority of nurses when dealing with doctors. May (1995) further argued that nurses are often subordinate to doctors in their relations because of the 'type' of knowledge that they have, but not because of the quality or the quantity of knowledge they have. This is

because their training often fails to prepare nurses to analyse and decide while making assessments.

Nonetheless, the ability of a nurse to become involved in stages beyond observation, or to move to a stage of ‘knowing’, seemed to be limited by many factors. A collection of organizational and socio-cultural factors influenced how nurses practised pain management, and, through the disciplinary power that placed nurses in subservient and, or, docile positions, when they wanted to practice in pain management. .

The disciplinary power exerted by organizational or socio-cultural factors seemed to serve three main purposes: i) it constructed and modified nursing actions, perceptions, and attitudes toward patients and their pain management (Holmes, 2006) to echo the culturally set traditions and boundaries between different genders; ii) it reinforced both the patriarchal male-female and hierarchical nurse-doctor relations (Doering, 1992); iii) and limited production of new nursing professional knowledge. However, it reinforced the development of a practical knowledge of roles and boundaries that embodied the interiorization of their relations with doctors, organizations and the public.

1. Disciplinary power: Role of organization

Hierarchical observation was the main disciplinary technique practised by organizations to exert influence on nurses’ practices. Hierarchical observations “coerce by means of observation; an apparatus in which the techniques that make it possible to see induce effects of power... mak[ing] those on whom are applied clearly visible” (Foucault, 1977: 170-171).

The findings showed that there were similarities in the panoptic practices that both hospitals used to impose power over nurses' behaviour, such as the regular inspections. One of the hospitals seemed to exercise discipline by creating an atmosphere of suspicion through covert inspections, although such practices were less frequently used in the other hospital.

Because of covert inspections, nurses always suspected they were being watched and judged by others. Whether these observers were other workers who were close to the administration, or patients' relatives, nurses referred to them as 'spies' (Chapter Six, Section Two, Subsection 1).

Nurses' use of the words 'spies' or 'spying' to describe covert inspections efficiently expressed the atmosphere of fear, suspicion, and mistrust that such practices of observation established among them. The feeling of being inspected seemed to modify nurses' practices, especially those in response to patients' pain and requests for painkillers. Some nurses settled for calling doctors and informing them about patients' pain conditions without any further action. In other situations, such inspections placed nurses in situations of ethical conflict where, for example, some nurses gave non-prescribed weak analgesics, such as Paracetamol or Diclofinac Sodium secretly and without any documentation, while others hesitated to ignore the painkiller administration policies. Nurses frequently expressed a feeling that they were limited in the help they could provide to patients by policies that restricted their authority, and only permitted doctors, who might not be immediately available, to prescribe medication.

In addition, the disciplinary power exercised through covert inspections had more destructive implications on the ground than that mobilised through overt inspections (Chapter Six, Section Two, Subsection 1). Politically, the covert inspections, given that they were undertaken by some team members, destroyed trust between nurses, and put them under continuous self-surveillance and fear. This served to limit their ability to act independently and to take initiative.

The organizations also exerted disciplinary power through their reinforcement of the hierarchical character of nurse-doctor relations. The organizations granted doctors wider authority than nurses, and nurses' interiorization of their marginalization by doctors was further reinforced by a set of organizational factors related to this hierarchical structure, and by the greater level of public respect attributed to doctors' knowledge and skills. The continuous marginalization of nurses by doctors, which was reinforced by the lack of organizational support (Chapter Six, Section Two), had several consequences. Some nurses started to learn to obey without questioning, playing an obedient role or docile role. The passive practices that resulted from this position had negative effects for patients, as well as for the professional status of nursing. Nurses avoided assessing patients in the presence of doctors and, in some instances, neglected to communicate patients' complaints of pain to avoid provoking conflicts or an abrupt response from doctors (Chapter Five, Section Two, Subsection 1). The negative and passive effects of nursing docility on nursing professionalism seem also to impact on self-regulation, which necessitates referring to

fellow professionals for help, or to evaluate and control work (Wynd, 2003; Hall, 1968). In contrast to this, when nurses were asked what they usually do when patients complain of pain, many said that they simply call a doctor, without even using their or other colleagues' capabilities to assess or manage patients' pain first. This finding agrees with Manias and Street (2001b: 132), who found that some nurses in a critical care unit chose to refer to doctors when, for example, a patient's drain tube was not draining, rather than refer to colleague nurses to trouble-shoot the drain tube.

The nurses' docility also reinforced the inferior public view of them and of their knowledge. Patients and their relatives frequently observed that nurses only called doctors and waited for their orders and did not make immediate action in progressing patients' cases (Chapter Five, Section Two).

Paradoxically, although nursing docility could be seen as a result of a disciplinary process of continuous *interiorization*, it seems itself to have become a disciplinary factor that nurses had *interiorized*, and therefore embodied in their willingness to learn more regarding pain management (Chapter Five, Section Five, Subsection 2). For example, when nurses were asked if they needed further information about pain management, many of them said that pain can be simply managed by painkillers ordered by doctors, and that there was no need for further information or for an updating of their knowledge (Chapter Five, Section One, Subsection 2). This suggests that some nurses had come to accept the orders and decisions made by doctors, and passively received them without feeling a need to develop or to query them, even if they did not suit a patient's condition.

Thus, the lack of ‘active lifelong learning’ or continuous updating of the theoretical knowledge (Starck, 2009: 371) seems to have had a further impact on nursing professionalism in both hospitals.

Not only was the self-regulation and life long learning of nurses affected, but also their autonomy. Nursing autonomy, which is an important trait of professionalism (Hall, 1968) seems to be partly effected by the organizational hierarchical structure. Nurses were placed in a subordinate position to administrators and physicians (Chapter Six, Section Two, Subsection 3) whose questioning of their performance lead to a feeling of over-determination and restriction, a finding that supports Oweis (2005), and Karadag, Hisar, and Elbas (2007).

Finally, the fourth trait of professionalism lacking in both hospitals studied was a clear job description and a code of conduct. The findings showed that both nurses and doctors did not have a distinctive vision regarding each others’ role in pain management. This in part produced role conflicts between them, and helped to establish a relationship in which each tried to dominate the situation, and impose their convictions and knowledge on the other. The findings of this study suggested that such ambiguity, and the conflict it created between nurses and doctors, could be a cause of the increased workload (Zakari, Al Khamis, & Hamadi, 2010) of which many participating nurses complained.

Participants reported there were nursing shortages. This, together with the lack of a clear job description, seems to have deepened the consequences of the absence of a local or national code of conduct for nursing. In the United

Kingdom for example, the code of conduct covers the nurse's ethical and moral responsibilities towards patients, including their responsibility for saving patients unnecessary suffering. While pain management is an ethical responsibility of health professionals (Rejeh, Ahmadi, Mohamadi, Anoosheh, & Kazemnejad, 2009; Rich, 2000), pain seems to have been a low priority for the nurses who participated in this study, who explained that staff shortages and the related workload divert their attention away from pain as a high priority.

So, the hospitals as organizations exerted disciplinary power through inspections and through reinforcement of the hierarchical nurse-doctor relations. The disciplinary power exerted its influence by encouraging nurses to *interiorize* fear of organizational punishment, and *interiorize* the domination of doctors. Nurses showed docility as a result of their *interiorization* of organizational panoptic surveillance and doctor domination. However, the docility that nurses showed may be seen as a choice, since, for example, they could choose to ask for their colleagues' expertise when patients' complained of pain instead of waiting for a doctor to come and write an order. Manias and Street (2001: 132) take this view, concluding that: "[nurses] had a choice about whether to draw upon nursing resources to rectify the situation or to call upon the doctor".

2. Disciplinary power: Role of socio-cultural context

Through a set of social panoptic practices, nurses also *interiorized* the shame that would result from public misinterpretation of their tasks.

Three aspects of Jordanian culture seem to have influenced nurses' practices and interactions in both hospitals: sexual surveillance, in specific that related to female-male interactions; patriarchy; and the public view of nurses' knowledge and tasks.

2.1 Gender relations and “sexual surveillance”

As discussed above, a lack of nursing engagement in patients' pain assessment and care was found to exist. Nursing *interiorization* of a collection of cultural considerations, which nurses described as 'fear of misinterpretation' played an important role in restricting nurses from moving beyond simple observation, and in some instances, even simple observations were restricted. Fear of misinterpretation was one of the themes which most frequently emerged from interviews with both nurses and patients about how they constructed their practices, preferences, and relationships with others, whether visitors or professionals, of the opposite gender. *Interiorizing* shame or fear of misinterpretation was based mainly on a fear of being falsely accused of unacceptable behaviour or interaction and inappropriate sexual conduct of any type, indicating that nurses were under both public 'sexual surveillance' and self-surveillance. 'Sexual surveillance' being a situation where: “any social relation between a woman and a man sparks off assumptions that sex is at the root of it” (Hollway, 1994: 256).

Because of their fear of having their actions misconstrued, the majority of female nurses in the male ward avoided entering male rooms during night shifts (Chapter Six, Section One, Subsection 1). The lack of assessment

during late night shifts had prompted some patients to take their own painkillers instead of going to the nursing station to ask for pain relief (Chapter Five, Section One, Subsection 4).

Female nurses' fear of having their actions misinterpreted was explained as having deep roots in the culture. Fear of the shame which might result from having their actions misconstrued seems to have been important among female nurses who protected themselves from such accusations by not getting deeply involved in the pain assessment or management of male patients.

The fear of misinterpretations and penalties, such as 'honour killing' in some cases, or shame more usually, formed a 'panopticon' (Foucault, 1980, 1977) (Chapter One, Section One, Subsection 3.2), where both the health professionals and patient felt that they were always subject to *gaze*, and under the eyes of others, even if they could not see others watching them.

The striking finding related to the panopticon metaphor is that participants, whether professionals or patients, always expected that they were being seen by others, even when they were not, an example of Foucault's ideas about the role of automated self-surveillance in disciplining behaviours. This idea might explain why female nurses refused to administer painkillers injections to male patients even when curtains were closed (Chapter Six, Section One, Subsection 1). The actual presence of others did not seem necessary to produce such practices, since the social disciplinary power induced its effect through *interiorization* even when surveillance was discontinuous (Foucault, 1977: 201).

Sexual surveillance did not only modify the practices of nurses, but also their response to organizational policies. Significantly, all female nurses who worked on the male patients' ward in one hospital refused a policy that required them to administer I.M injections when needed by patients regardless of their gender. Such a policy did not take into account the male patients' response to such nursing practice, given that all participating male patients showed more interest in being cared for and injected by male nurses rather than females. Nurses' refusal to follow such a policy indicates how strong the influence of social culture was within the organization. This influence was, I think, reinforced by factors from within the organization itself. For Jordanian nurses, a number of factors such as the lack of professionalism discussed earlier; or the tendency to approach work as a person more than as a professional, or to work individually rather than as a member of a team, might have made overriding the customs of the working environment hard.

However, the debate regarding the potential origin of the fear of shame needs to be clarified. Prior to the fieldwork, a presumption that Islamic heritage might have an influence over female-male interactions and accordingly their practices was identified. However, during the fieldwork, this assumption was shown to be insufficient. Nurses verbalized the influence of cultural norms on their actions even before this issue was addressed in interviews (Appendix Eight B). In addition, most nurses distinguished between the effect of the religion and the culture, although many public discussions conflate the two, as Brand (1998) and Shoup

(2007) wrote [Chapter Two, Subsection 5.3]. Only two nurses said outright that they avoid touching patients for religious beliefs, while most nurses simply stated that it was a cultural, more than a religious, attitude. However, it is worth mentioning that although nurses' behaviours were not justified or explained by religious belief or observance, the cultural norms concerning appropriate gendered behaviour were socially constructed and influenced by the different social interpretations of Islamic views regarding, for example, patriarchy and social gender segregation.

Thus, the fact that participants were aware of the influence of their socio-cultural context suggests it has a strong effect on them, although it should be acknowledged that socialization could have the potential to decrease such awareness.

2.2 The extension of the patriarchal position of males into Jordanian hospitals

The effects of patriarchy were displayed both through the practices of female professional and patients who *interiorized* patriarchal ideas and acted according to them, and it was displayed by male professionals and patients in their relations with female nurses and patients.

Patriarchal ideas seemed to exert a marked effect on the consciousness of participants, and accordingly their practices. In both hospitals, many female nurses tried to avoid engaging with patients or professionals of the opposite gender by modifying their actions and practices to correspond with their male relations', and especially their husbands' preferences, even when these males were absent. The resultant nursing practices included avoiding

looking at patients' bodies, or at what they called 'private areas', or an avoidance of talking and laughing with patients to avoid provoking anger of husbands, and other male relatives. While the 'private areas' included only genitals for a few nurses, for the majority, and especially for female nurses when working with male patients, it was more extensive and included the abdomen, chest, back, and legs.

The patriarchal ideas seemed to exert influence on participants' consciousness, which is a finding not supported by Foucault, whose works went far from the discussion of power and consciousness (Foucault, 1980). Thus, it was important for me to turn to other philosophers to explain the effect of the ideas on people's actions and practices, and the lack of resistance to such ideas.

Neo-Marxists see the effect of power as elicited at the level of consciousness (Foucault, 1980). The insights of Neo-Marxists, and especially the ideas of Gramsci, regarding the hegemony of ideologies (Gramsci, 2000; Bates, 1975) might explain why nurses adapted to subordination, or internalized marginalization and cultural issues, such as patriarchy, without resistance to cultural norms. Thus, setting aside for now the debate between Foucault and the Neo-Marxists about which controls the other, the body or the consciousness, it seems evident that patriarchal ideas strongly influenced the practices of participants in my study.

Nurses seemed to internalize cultural traditions and ideas, and reflected them in their actions and attitudes. As outlined above, nurses internalized, but did not resist their cultural contextual factors, and adapted them to resist

the organizational policies. Thus, there is, for example, a difference between the docility produced because of the socio-cultural disciplinary power, and that produced by doctors' domination or hierarchical observation in both hospitals, for example.

The difference is that nurses' docility in response to socio-cultural factors resulted from hegemony. Thus, docility or an unquestioning acceptance of subordination was arguably inevitable in this instance, since resistance to culture seemed impossible individually due to "societies not [being] willingly accepting of change, and if alterations are to permeate significant social institutions, the processes of transformation are very tenuous" (Miller, 2009: 15), even by organizational decrees:

*"...We cannot change the society's tradition by a written order."
(Observation (4); S.M; M.H; Shift (B); 7:00pm)*

However, the docility that some nurses showed in response to doctors' domination, was, I think, a choice, because it was observed that some other nurses chose to resist by avoiding applying orders literally, for example (Chapter Five, Section Two, Subsection 3).

Among the many positions that nurses placed themselves in, or were forced to adopt, the docile and 'disciplined' nurses roles were those which most frequently emerged from fieldwork. Nurses applied their own customs when they interacted with patients and other professional members, including those customs that prohibit or prevent engagement with patients of the opposite gender, such as touching patients of opposite gender, looking at their incisions, or asking them about their pain in case of surgeries in 'private areas'. The self regulating norms of nurses seemed to be driven not

by a separate professional culture, but by the wider public culture, in which health organizations are immersed. The relatively weak effect of organization on the construction of nurses tasks, compared with the significance of the prevailing culture, emerged because each member in the organization worked as a person, and each person *interiorized* social customs and traditions rather than professional standards. Consequently, this clearly made the cultural effect more visible, profound, and influencing within institutions.

The discussed findings above showed clearly that cultural customs were present when the parties involved in any interaction were of different genders. The next section sheds light on the possible factors that might influence nurses' practices when they are involved in care of patients of the same gender.

2.3 Gendered power relations or strong power relations among participants of different genders?

Issues related to interactions between people of opposite genders and the subsequent effect on their practices were an expected element because the Jordanian culture is, to a large extent, concerned with male-female public interaction, as professionals and patients said (Chapter Six, Section One). However, unexpectedly, the majority of nurses who worked with patients of the same gender undertook pain assessment practices and interventions similar to those undertaken by the nurses who worked with patients of the opposite gender. For example, female nurses in the female patients' wards showed a lack of practice and engagement with patients' pain assessment

and care; did not utilize any non-pharmacological pain intervention including patients' body touch, or therapeutic humour; and, in many instances, administered I.M painkillers injections in the deltoid muscle rather than in the gluteus or femoral muscles (Chapter Six, Section One). In addition, female nurses in the female patient wards, similar to female nurses in the male patient wards, did not check patients during the late hours of night shifts, and often did not check patients' incisions postoperatively. It seems that the cultural explanation is insufficient for such a finding.

For this unexpectedly emerging issue, there are two possible explanations. The first explanation is that nurses might have been more willing to do things in the easiest way. However, this explanation could be seen as superficial and blames nurses, ignoring the contextual factors which might have led anybody placed in the same conditions to exhibit similar practices.

The second explanation relies on the poststructuralist perspective, which is that gender might be only one possible source of the difference in power among the interactions of nurses and patients in the studied hospitals, but not necessarily 'the' only one.

My research findings are different from the findings of other research that studied the practices of people of the same genders in clinical settings. Because there is a lack of research studying the power relations and practices between nurses and patients of the same gender in Jordan, available Western studies that investigated this topic were used to clarify my point.

Gjerberg and Kjolsrod (2001), via a study conducted in Norway, examined all-female doctor-nurse relations. They found that the doctor-nurse relation was influenced by the doctors' gender rather than the professional status. It revealed also that female doctors were treated with less respect, less confidence, and were provided with less help than their male colleagues. In a Canadian study, Zelek and Phillips (2003: abstract), argued that these practices might occur because "when nurses and doctors [or nurses and patients] are females, traditional power imbalances in their relationship diminish, suggesting that these imbalances are based as much on gender as on professional hierarchy". Zelek and Phillips suggested that this type of practice "speaks to the primacy of sex over hierarchy in defining the doctor-nurse relationship" (2003:2).

The two studies suggest that when the gender of nurses and doctors is the same, the power imbalance diminishes. However, other researchers such as Rothstein & Hannum (2007), who conducted a study in USA, showed that the relationship between professionals is based mainly on the model of interaction between 'professionals' rather than the model of interaction between 'genders'. Although the cultural settings are different, this might help to explain why, in my study, female nurses interacted with female patients in a similar way to the way female nurses interacted with male patients. It might be, as Rothstein & Hannum (2007) found, because female nurses, working in female patients' wards, dealt with patients on a traditional hierarchical basis when the gender basis was absent. In other words, in the absence of gender relations, the nurse-patient relations in

female wards may have been built on the basis of traditional hierarchical tactics which require that some part “will always be positioned as inferior” (Crowe, 2000: 965). Potential factors that might have kept this power imbalance in place, even though the gender was similar, are the nurses’ knowledge about patients’ cases, and the fact that patients were situated within the health professionals’ organization or space, so that:

“...When patients enter hospitals they enter highly politicized arenas...the hospital is the home terrain of the staff, especially of physicians and nurses... The staff does possess many advantages flowing from a familiarity with the terrain, greater knowledge and information, authority, and legal or institutional responsibilities” (Fagerhaugh & Strauss, 1977: 9).

Because the hospital is the home terrain of nurses, and because nurses are more knowledgeable about patients’ cases, patient dependency on nurses is reinforced, placing them in the inferior position.

This explanation does not in any way deny that the power imbalance observed between nurses and patients of different genders was greater than that shown to exist between nurses and patients of similar genders. Instead, this indicates that gender is only one factor that deepens the power imbalance, but that where both parties in the nurse-patient relations are of the same gender this does not eliminate the power imbalance completely.

The importance of discussing the power imbalance between nurses and patients lies in the understanding that, “power/knowledge differences have direct or indirect ethical implications for clients, health professionals and the community” (Peter, Lunardi, & Macfarlane, 2004: 403). For example, when

power differences are extreme, patients might be vulnerable and might experience difficulties making decisions regarding the health care services presented to them (Peter, *et al.*, 2004), or the pain they experience.

2.4 Public view of nurses: Further impacts on professionalism

The findings suggest that the public and hospital administration still do not value nursing practice or knowledge, or nurses as autonomous decision makers in acute settings. This is shown through the patients' views that nurses were doctors' handmaids or assistants. The inferior view of the knowledge and skills of nurses was also shown through patients' pain practices, such as hiding pain from nurses and waiting for doctors to complain about pain, or patients only allowing doctors to examine their bodies (Chapter Five, Section One, Subsection 4). These findings suggest that patient trust in doctors' knowledge, competence, and status was high in comparison to that granted to nurses, confirming the findings of other studies conducted in Jordan, such as Haddad *et al.*, (2004).

According to interviews conducted with nurses and patients, the inferior public view of nurses has four main sources: media (Chapter Five, Section One, Subsection 4), which will be discussed later; the practices of nurses in previous hospitalization experiences; organizational policies that limit nurses' authority; and doctors' marginalization of nurses' skills and knowledge in front of patients (Chapter Five, Section One, Subsection 4; Chapter Five, Section Two, Subsection 4). The feeling of marginalisation, whether by doctors or patients, seems to reduce nurses' ability to act with autonomy.

In this study, participating nurses were often unable to make decisions related to pain management independently, even though there are no policies or official documents preventing them from doing so. They reported that their ability to make decisions was constrained by many factors, such as the jurisdictional boundaries that doctors placed on their daily work; the limited authority they were granted by the organization; the continuous organizational observation they were subjected to, whether covert or via routine inspections; the lack of a job description, which left ambiguity over nurses' roles; public surveillance of their interactions and practices with patients, relatives, and other professionals; and, most importantly the public view of their knowledge and capabilities.

This concludes the examination of nurses' pain practices and the factors influencing them. The next section discusses nurses' knowledge of pain, and the ways this knowledge is constructed from various different factors.

III. Nursing knowledge: How do nurses construct their knowledge regarding pain?

The forthcoming subsections discuss the types of knowledge that nurses had regarding pain; the effect of formal education in building theoretical knowledge; and the effect the ward culture and interactions with other professionals had on building experiential knowledge and roles. Meanwhile, two points need to be considered. First, nurses' theoretical knowledge of pain was not thoroughly explored in my research since the main focus was on understanding what nurses did to assess and evaluate patients' pain, rather than to examine theoretical knowledge itself. However, the emergent

themes efficiently reveal how nurses' experiential knowledge was constructed. Second, in the literature, there are inconsistent findings regarding the influence of nurses' knowledge on their practices. For example, some studies suggest that university education and nurses' knowledge are an important element in building nurses' pain management practices (Lui, *et al.*, 2008) and decreasing pain scores, but other research suggests that there is no significant relationship between this knowledge and nurses' practices or pain scores of patients (Watt-Watson, *et al.*, 2001).

1. Formal learning: Theoretical knowledge

The curricula review at both studied universities revealed that on average nursing students spend less than an hour during their four years of nursing study learning about pain and its management. The majority of their attention is directed to studying patho-physiological disorders and signs. The curricula review also revealed that pain is taught mainly as a symptom related to other disorders and minimal attention is therefore focussed on pain itself. This finding echoes other studies worldwide which found that nursing educational curricula related to pain are still inadequate and minimal (Watt-Watson *et al.*, 2004). For example, Rahimi-Madiseh, Tavakol, & Dennick (2010) reported that in a pharmacology course, only 3 out of 51 hours were directed to the teaching of painkilling medicines, and in the majority of nursing courses, students were familiarized with pain as a symptom of a disease rather than a symptom or a subjective phenomenon *per se*. In a study conducted in Hong Kong, Lui, *et al.*, (2008: 2017), reported that "pain assessment and management are not specifically

identified in the syllabus... only limited attention is given to pain management in the nursing training programme”. Pain was not given a priority in any reviewed curriculum and was inadequately covered even as a sign of other patho-physiological disorders. Thus, pain seems not to be seen as a priority in practice among graduated nurses, and this accords with many nurses’ interviews (Chapter Seven).

On the other hand, taught programmes relied totally on Western textbooks that included models of pain management that did not directly transfer to the Jordanian culture. For example, the language of education, which is English, is very different from both the formal Arabic that all Jordanians understand, and the vernacular language that Jordanians speak in daily life (Chapter Two, Subsection 4). In addition, Western textbooks that are taught in both schools recommended some non-pharmacological intervention such as massage, supportive touch, and therapeutic humour. Although using such techniques forms only a small part of the overall postoperative pain management, many professionals and patients emphasized their incompatibility with Jordanian culture. Even physical examination by inspection or palpation for female nurses was felt far from compatible with Jordanian customs which aimed to avoid exposing patients before nurses of opposite genders.

Western models of pain management also do not transfer in terms of the pain assessment tools used. That is, there were challenges with using the NRS in Jordanian hospitals.

Although many precautions were taken to ensure the reliability of measurement, such as interviewing patients without the presence of others where they agreed (Chapter Three; Subsection 4.6.3), the culture of stoicism influenced patients', especially male patients', tendency to report pain to the researcher. It seems that shyness and the stoicism of patients, especially males, might have been constructed culturally, supporting findings of Davidhizar and Giger (2004). A more detailed discussion of stoicism among surgical patients is introduced later in this chapter.

Another issue that seemed to make using pain scales challenging is the different expressions and conceptions of pain severity that different patients had. For example, patients who could not score their pain described the experienced pain and related distress using their own words; could not provide a discrete number to describe their pain intensities; or chose to score severe pain by numbers above 10 (Chapter Four, Subsection 1). While some patients used 'a thousand' as a score for the most severe pain, some of them used 'a million'. This suggests that the 10, 20 or 100, which the NRS commonly uses to describe the score of the most severe pain, was felt insufficient to fully describe how severe some people felt their pain to be. This might suggest that patients' views of pain severity are different, indicating that the problem might not be the scale itself but the different conception of pain severity of different individuals in various contexts. This issue also indicates that the NRS seems to limit some patients' idiosyncratic subjective description of pain intensity to certain numbers, and accordingly hides patients' real emotive descriptions regarding the ceiling of their pain intensity, as reported by Williams, Davies, & Chadury (2000).

On the other hand, patients were unfamiliar with pain scales and this might have negatively influenced their ability to score their pain severity. Given that “using a scale to assess pain is a (*sic*) learning and participating process for patients” (Li, *et al.*, 2007: 231), patients’ lack of familiarity with pain scales could be expected given their infrequent use by nurses. Thus, and agreeing with Li *et al* (2007), further education is recommended if pain scales are to be used by Jordanian patients.

Therefore Western textbooks that recommend using the NRS among patients for assessment of pain seem not to transfer directly into Jordanian clinical settings. This is because of the lack of patients’ familiarity with such tools, and more significantly, because of some cultural considerations, such as stoicism.

2. Interacting with other professionals in daily working life: Practical knowledge of roles and boundaries

Part of nurses’ knowledge regarding their role in pain management was constructed through their continuous interaction with professionals, mainly doctors, in daily work in both hospitals. In the literature, doctors are recognized as a source of nursing knowledge formulation and development: “Nurses... drew on practical and experiential knowledge developed through peer relationship”, especially with the doctors who worked with them in the critical care unit (Manias & Street, 2001b: 133). Given that nurses: i) did not have a clear job description regarding their roles in general and in pain management in particular, ii) and did not have enough education regarding their roles in pain management when working with other professionals, findings showed that nurses seemed to learn their roles mainly through their

interactions with doctors (Chapter Five; Section One; Subsection 2). Because of worries about being 'berated' or marginalized, or because of a fear that their suggestions and discussion might provoke abrupt responses from doctors, nurses learnt to be silent, and to refer any patient complaint of pain to doctors. That is why, as some nurses highlighted, patients' pain complaints were sometimes lost because of problems with nurse-doctor communication and discussion regarding patients' pain.

3. Foreground knowledge

The lack of nursing engagement in patient assessment provided nurses with only the objective foreground knowledge (May 1992) rather than background knowledge, leading to what Fagerhaugh & Strauss (1977) described as a splitting of a patient's pain from its context. Nurses, and even doctors, showed a limited knowledge regarding some aspects of patients' social backgrounds and biographical data. Thus, background knowledge was not a significant concern of professionals in their work with patients, supporting findings of Fagerhaugh & Strauss (1977).

Further, both nurses and doctors seem to have failed to benefit from the knowledge of relatives of patients, or the 'foreground knowledge of relatives'. Under appreciation of this area of knowledge clearly represented the loss of a way to assess patients' pain, especially that of those who are stoic in their characters (Chapter Six, Section One, Subsection 4, 5).

The social and cultural factors discussed earlier had, to a large extent reinforced nurses' adherence to foreground knowledge rather than

background knowledge, especially among females, by restricting engagement in patients' cases, and restricting access to more information. Some organizational issues, such as the low nurse-patient ratio, which was often 1:13 (Table 9, Chapter Six, Section Two), also reinforced the absence of nurses' involvement with patients.

These conditions had together entrenched an approach of working with patients according to the 'task oriented care delivery model' which does not rely on involvement with the patient holistically as the centre of the care process. In Jordan, the task oriented model of care corresponds with the cultural norms of nurses who preferred disengagement with patients of the opposite gender. The task oriented care delivery model also corresponds with the nursing shortage and the heavy workload which nurses, even those who worked with patients of same gender, stressed during interviews. A major concern regarding the task oriented care delivery model is fragmentation of the patient's care, leading to omitting or overlooking some problems (Thomas, 1992), especially those reported subjectively by patients.

In conclusion, nurses had some theoretical pain knowledge provided through initial training, some practical knowledge constructed through the daily interaction with doctors, and a foreground knowledge which they relied on when working with patients' conditions. However, there is a clear lack of nursing background knowledge regarding patients. The importance of this knowledge is that it enables nurses to become familiar with those characteristics of a patient's background which have an effect on how they

respond to pain and interact with staff in the hospital environment (Fagerhaugh & Strauss, 1977).

IV. Potential factors influencing patients' practices in postoperative pain management process

It is the patient who has the complete and original story regarding the description of their pain experience. In addition, the extent to which patients' practices influence pain management also has an influence on the effectiveness of any suggested pain management protocol or policy. Therefore, determining the factors that influence pain management from the patients', as well as the professionals' perspective, helps create a more comprehensive analysis of the case.

A close look at the findings reveals that the postoperative pain practices of Jordanian patients were either 'stoic', 'emotive' (Davidhizar & Giger, 2004: 51), or both, reflecting dominantly their cultural context. 'Stoic' means that "individuals are less expressive of their pain and tend to grin and bear it", while 'emotive' means that "individuals are more likely to verbalize ..." (Davidhizar & Giger, 2004: 51), or to physically express their responses to pain and to professionals' practices.

1. Patients' practices in light of the socio-cultural context

Restrictions related to gender relations, which are usually observed in the wider society, imposed themselves strongly in patients' rooms and constructed their responses to pain and to professionals' practices. These restrictions were applied mainly through sexual surveillance that led to all

other culturally constructed practices, such as a decreased willingness on the part of patients to be physically exposed to professionals of other genders, and a tendency to hide pain or to be stoic in certain situations.

1.1 Sexual surveillance

The public surveillance or *gaze* that was practised over professionals and patients had exerted power and influence because it was ‘analytic’ in nature. This is because the surveillance that people practised in patients’ rooms did not stop at observation, but continued with the interpretation and analysis of the observed practices, and evaluation of their compatibility with Jordanian culture and norms. The *gaze* that was practised by the public included judging others, whether professionals or patients. Thus, professionals and patients feared misinterpretation of their actions because they might be judged and exposed to penalties, such as shame.

It was discussed previously that as a result of sexual surveillance and the fear of misunderstanding, professionals adopted practices to correspond to the cultural norms. Sexual surveillance also constructed patients’ practice and preferences. For example, the majority of patients preferred being cared for by professionals of the same gender, and this concurs with other studies conducted in Jordan (Ahmad & Alasad, 2007). Ahmad & Alasad (2007) reported that although patients of either gender preferred professionals of the same gender, this trend was stronger among female patients than among male patients. This might be explained by females’ interiorization of the norms that often look upon, as Shoup (2007) reported, females as more

responsible for keeping family honour than males (Chapter Two, Subsection 5.3).

In some studies, such as that of Simpson and Carter (2008), internalizing cultural norms and the fear of penalties produced a feeling of guilt when any interaction happened between a female and a male. Simpson & Carter described the experiences of seven Muslim women in rural areas of the United States, and reported that women have feelings of guilt when shaking hands with male health professionals. Simpson and Carter found that “the women demonstrated that they were more comfortable, it preserved their modesty, and it was more culturally appropriate if they were seen by female providers.” (Simpson & Carter, 2008: 20).

In my study, *interiorization* of the shame that would result if patients’ responses to nurses’ tasks were misinterpreted caused most patients to reject any anticipated use of non-pharmacological interventions, such as humour, therapeutic touch, massage, and other interventions that involve touching patients’ bodies.

However, as mentioned earlier, sexual surveillance is not sufficient to explain the display of similar attitudes in female-female relations. As discussed earlier, the power relationship between nurses and patients seems to be built more on a model of profession than on a model of gender. The fact that power differences are evident despite both parties being of the same gender can be attributed to nurses’ superior knowledge and professional status over patients, and this might explain why some female patients hide their pain from female nurses.

1.1.1 Visitation customs: Reinforcement of sexual Surveillance

The fear of sexual surveillance, especially aural surveillance exercised by strangers', and the public view of individuals who express their pain outwardly, had affected patients' willingness to express and communicate their pain, reinforcing stoical responses. This influence was deepened by hospital visiting customs which allowed the presence of large numbers of people in the same space with patients. This could be seen as a public *gaze* over patients and professionals alike. Some patients, especially females, had *interiorized* the anticipated shame and potential public criticism they felt would result if they voiced pain in the presence of strangers (Chapter Six, Section One, Subsection 3). This public *gaze* practised during visiting time has not been referred to in any other research conducted in Jordan.

Paradoxically, the same public *gaze* that had negative and restricting effects on the practices of professionals has been described by patients positively when it was exercised by their relative visitors. Many patients said that being visited by their families and relatives made them feel socially supported (Chapter Six, Section One, Subsection 5), confirming the findings of other studies conducted in Jordan such as Zeilani & Seymour (2010), and studies conducted internationally such as Potter & Perry (2001).

This paradox might have many potential explanations. According to Foucault, *gaze* might be a double-edged way of exerting power. It restricted nurses' practices and played a disciplinary role when it was turned on nurses' practices. It also impacted on patients' willingness to express pain outwardly when surrounded by strangers. However, "the gaze that is turned

upon [patients] by those close to [them] has the vital force of benevolence and the discretion of hope” (Foucault, 1975: 46).

Given that they have a foreground knowledge of patients, relatives tended to fill gaps in the services nurses provided, and to be closer to patients. Thus, the gaze that was exercised by relatives upon patients seems to have advantages for the pain management process outcomes in many, but not all cases, because patients seemed to feel more able to explicitly express their pain to relatives. It seems likely that this is why nurses reported that ratings of patients’ complaints of pain increased markedly during the visiting hours (Chapter Six, Section One, Subsection 5). Thus, some patients seemed to be less stoic in presence of their relatives, and seemed to communicate their pain to relatives more easily than to nurses.

1.2 Stoicism

Although stoicism might be considered a culturally constructed response to pain (Davidhizar & Giger, 2004), it was not totally a product of sexual surveillance. Other factors, such as patients’ adaptation to professionals’ actions had also reinforced stoic behaviours.

Although a stoic response was common among many patients, this does not deny that stoic patients and many others showed emotive responses to pain by moaning, crying, and screaming, especially when dealing with professionals of a similar gender. Stoic responses, rather than the emotive responses, seem to be complicated and induced by a set of intertwined factors, whether organizational, or social such as: patients’ view of different professionals, female patients’ interiorization of males’ patriarchal position,

or male patients' interiorization of pride and masculinity, as well as a response to nurses' disciplinary practices.

1.2.1 Stoicism, and Masculinity and patriarchy

Males' hiding of or reluctance to report pain can be partly explained by the social expectations men developed during the childhood socialization process (Bendelow, 1993). In this study, male patients' hiding of pain was often prompted by a sense of male pride, derived from the public view of masculinity, and the respected position of males in the Jordanian family (Shoup, 2007). Male patients seem to have internalized the social expectations and public view of their roles and masculinity, and behaved according to these, showing how participants are disciplined to behave according to a socio-cultural expectation of stoical behaviour, especially in public settings.

In the cases of female patients, many patients and relatives could establish a new understanding of factors that potentially provoke stoic responses to pain, whether in hospitals or in their homes. It was mainly female relatives who revealed that female patients hide their pain to prevent their husbands or the public in general from viewing them as weak and ill, and some patients confirmed this view. Patients and relatives emphasised that they saw the potential consequences of being viewed as an ill woman as catastrophic for a female's feelings of femininity and youth, and in some instances women feared that such views, if established, could undermine their marriage and even lead to divorce. This is because a husband might start searching for a younger healthy woman for marriage or other types of

relationships (Chapter Six, Section One, Subsection 4). The fear of being marginalized from their husbands' life was obvious and could prompt female patients to act stoically, as well as delay them from seeking medical care.

On the other hand, the superior position that was occupied by or culturally granted to males, regardless of their age, limited female patients' willingness to communicate pain outwardly. Male professionals' positioning of female patients as equivalent to their wives, sisters, or daughters, "over whom [their] patriarchal authority was in principle firmly established" (Hollway, 1994: 261) could clearly serve to decrease female patients' willingness to communicate their pain to doctors.

Whether shown in the exercise of patriarchal authority as a brother, a husband, or a father *over* female patients, or in male's practising of respect for females through their patriarchal position as a son, "the patriarchal model of family relations [surfaced in] the gender relations of organization" (Hollway, 1994: 261).

On the other hand, my findings revealed that some stoic patients expressed severe and even agonizing pain using mild expressions that nurses and doctors mostly did not consider. Because of their foreground knowledge regarding patients, some of the relatives knew that their patients usually do not cry, shout, or even talk about their pain, but upon this hospitalization, they did so. This indicated that the pain they felt was very severe and hence pushed them to break their usual silence and to express pain outwardly.

The type of patient's response to pain is important in making pain clear for professionals to deal with or making it difficult to be assessed. Stoic responses and shyness mean that patients might experience pain silently without their pain being revealed to professionals. This, as Winefield, Katsikitis, Hart, & Rounsefell (1990) wrote, might worsen the patient's pain condition, especially if the painkiller is prescribed on a PRN basis, which requires that the patient asks for pain relief (Chapter One, Section One, Subsection 1.1).

1.2.2 Stoicism as a response to nurses' disciplinary practices

Although many researchers, such as May (1992), described patients' unwillingness to communicate pain or practices of hiding pain as actions of power by patients, since they block nurses' access to knowledge regarding their cases and pain, in my study hiding pain did not seem to be a practice of power or resistance since nurses relied on patients' objective indicators to assess pain, rather than on their subjective self-reports. Instead, patients' hiding of pain seems to emerge as a response to nurses' disciplinary practices; the patients' inferior views of nurses; and because of cultural considerations as discussed earlier.

Some nurses' practices, such as frightening patients with the complications of painkillers, especially addiction, had to a large extent prompted many patients to conceal their pain, and to tolerate it without complaining to staff. Other nurses' practices such as asking a patient to tolerate pain and do activities such as walking, sleeping, or moving in the bed, gave an indication that pain is not a serious health problem and can be overcome

easily. In addition, by asking patients to tolerate pain, nurses demonstrated to patients what the acceptable response to pain is within their organization. As mentioned earlier, the presence of patients in a strange setting, which is the “home terrain of the staff, especially of the physicians and nurses” (Fagerhaugh & Strauss, 1977: 8), might have reinforced patients’ adaptation to nurses’ practices.

Other factors that induced stoicism among patients were the lack of trust they commonly displayed towards nurses’ tasks, and the inferior view that the public has regarding the nurses’ job and knowledge. Four main factors have been identified as playing a role in the construction of this view: nurses’ practices in past hospitalization experiences; organizational policies that limit nurses’ authorities; medical marginalization of nurses’ skills and knowledge in front of patients; and the effect of the mass media. The former three issues have been discussed earlier in relation to factors which influence nurses’ practices, the next subsection discusses the effect of media.

1.2.3 Cultural governmentality through non-governmental institutions: the effect of mass media

The findings suggest that mass media has a role in constructing patients’ and relatives’ views of nurses’ knowledge, job, and nurse-doctor relations. Interviews with nurses revealed that the images produced in the mass media, in Arabic series and movies, showed nurses as servants and even *paramours* of doctors, and contributed to patients’ inferior views of them. This in turn contributed to some patients’ inclination to hide their pain from nurses, waiting instead to speak with doctors. The Jordanian public has a lack of

trust in nurses' tasks, and a strong belief in doctors' competence. This suggests that the media succeeded in embedding, whether intentionally or unintentionally, its images or 'hyperreality' of nurses (Baudrillard, 1983: 146) in the public's consciousness. The mass media seemed to influence the views that patients had of nurses, and accordingly, the way they behaved or reacted to nurses' actions. Such directing of the population's thinking about issues, given that the action of thinking about any issue is "a collective activity" of an entire section in the society rather than an individual activity (Dean, 1999), is a form of governmentality (Dean, 1999; Foucault, 1991)

The mass media could, as nurses pointed out, successfully lead the public's thinking about nurses, and create images of nursing and nurses among the public, which then became real in the minds of patients and are reflected in their practices with nurses. This finding supports other studies which referred to the potential negative effects of the media on patients' use of nursing services (Kalisch, Begeny, & Neumann, 2007; Kalisch & Kalisch, 1986; Kalisch & Kalisch, 1983).

However, patients were not wholly accepting of and passive towards nurses' practices. The next subsection explores the ways in which patients resisted staff's marginalization of their pain complaints. This resistance included verbal and physical violence.

1.3 Violent practice as a form of resistance

Chapter Five (Section Two) showed that patients and their families' resistance turned critical when they expressed it in a form of violence, whether verbal or physical.

The poor image of nurses among patients and their relatives was expressed verbally because of dissatisfaction with the care presented to them, or because they felt their pain was being ignored (Chapter Five, Section Two). Patients described nurses negatively in many instances, whether directly to nurses, or during interviews. In other studies, patients viewed nurses favourably and more positively, often as 'benevolent, virtuous and admirable', and 'ministering angels' or 'angels of mercy' (Muff, 1982). This difference in patients' views of nurses in different settings might be attributed to two factors. First, patients' views of nurses may have been partly constructed by the media, as discussed above. Second, patients' past or current hospitalization experiences might have led to them constructing images of nurses, and accordingly influenced their reactions during the current hospitalization. It should be noted however that patients rarely described doctors negatively. This might be because of the superior position that doctors have in Jordanian society, as well as the potential role of the media in depicting a positive image of doctors.

Some patients showed resistance in the form of physical violence. In Jordan, physical violence against nurses and doctors is an issue that has arisen recently, but insufficient empirical studies are published in this area. Only one study published recently has examined the problem and reported that about 22.5% (n=420) of registered nurses in four public hospitals were exposed to physical violence in their workplace (AbuAlRub & Al-Asmar 2011). Such incidents are usually documented in both the Nursing and

Medical Councils, in addition to the daily and weekly public newspapers (Appendix Ten).

According to Foucault resistance actions in power relations are not actions over persons but actions over their practices (Foucault, 1982a, 1982b). This argument agrees with both Peter, *et al.* (2004) and Wrong (1979), who rejected referring to physical violence as a practice of resistance. Peter, *et al.* (2004) and Wrong (1979: 10), argued that practices of violence are not practices of resistance because they make the subject against which resistance is applied a “physical object” rather than an action subject. In this study, patients’ attempts to hit nurses can be considered as actions of resistance to nurses’ practices, especially in light of the over-determining circumstances that patients were placed.

Findings, on the other hand, showed that patients directed their anger and violence to male nurses more than to doctors, supporting many reports in Jordanian newspapers (Appendix Ten). This practice might be prompted by other factors such as the commonly held inferior view of nurses, and the public respect for doctors, especially in military hospitals. However, the fact that violence was usually directed at male nurses, rather than female nurses, might be attributed to the patriarchal requirement that, in public at least, males protect females and do not hit them, although many physical violence attempts might take place in private.

V. Use of personal influence (*Wasta*)

The use of personal influence (*wasta*) emerged as an unexpected factor in the findings as it was shown that professionals and patients considered it a factor in the quality of care received in the hospitals.

The use of personal influence (*wasta*) impacted on nurses' work with patients' in pain by increasing their workload, as well as enhancing the quality of pain care presented to close relatives and kin patients, but not, and sometimes at the expense of, stranger patients. In addition, The use of personal influence (*wasta*) was shown to influence the punishment system in hospitals when, for example, nurses and doctors with good personal relationships conspired to cover each others' faults, such as some nurses' failure to give painkillers regularly according to a doctor's order (Chapter Six, Section One, Subsection 6).

The use of personal influence (*wasta*) is another culturally constructed issue, similar to patriarchy and sexual surveillance, which had an influence on hospitals as organizations. This suggests that the cultural influence is superior to the organizational, considering that organizational decrees could not change or modify convictions and attitudes that are culturally constructed. Instead, the use of personal influence (*wasta*) seemed to interfere at the organizational level and to influence the organizational penalties on professionals; was able to reinforce hierarchical relationships between nurses and doctors; and was able to influence the presented treatment and pain care presented to some patients over others (Chapter Six, Section One, Subsection 6).

The lack of professionalism, including absence of a code of professional conduct, as well as lack of organizational protocols that organize working with patients on the basis of equal rights, seem to enhance the effect of social phenomena, of which the use of personal influence (*wasta*) is one example, within the studied hospitals.

VI. The influence of space

Within spaces, or spatial arrangements of surgical wards, Foucault's perspectives of 'surveillance', 'gaze', 'discipline', and the practices of power and resistance were applied on the ground. The previous discussion shows that the hospitals are divided into spaces which are political arenas *per se* (Foucault, 1994).

A special characteristic of the hospitals studied is that they were divided into spaces where a primary discourse dominated the situation in each different stage of the patient's hospitalization experience. A general impression emerged upon an interpretative reading of the findings that the medical discourse was dominant in the operating theatre. When the patient was discharged from the operating room and received by nurses in the surgical ward, the nurses dominated the situation. Finally, when patients entered their rooms, it was noticed that socio-cultural factors became dominant. However, socio-cultural contextual factors showed an effect over all spaces because they were already embedded in the bodies and convictions of participants, whether professionals, patients, or visiting relatives.

It was not only the discourses included in spaces that influenced the participants' actions, but also the structural space itself. The architectural structures seemed to influence the nurses' behaviours, responses, and preferences. For example, nurses had a higher tendency to respond to patients' complaints if they were in rooms close to the nurses' station, and ignored others' who were further away. How nurses would have behaved had all the rooms been the same distance from the nursing station, or whether a change in spatial arrangement would have made a difference, are important questions for the pain management process.

In addition, nurses added a preferential criterion to the close rooms by placing patients who were relatives or friends in these rooms, making them special spaces with a power characteristic. The proximity of rooms to the nursing station was also a characteristic of private rooms in the military hospitals. For example, the private wings which only received patients of high rank were all close to the nursing office and doctors' office. This observation raises the question: which is more influential, the space or the people? In the previous sections of this chapter, it was assumed that spaces embedded with discourses granted individuals power through their discursive practices and knowledge. However, when spaces are divided according to the status of people who inhabit them, it seems that it is the subject who grants the power to the space.

This brief discussion regarding the effect of the building's spatial layout on nurses' practices supports the idea that buildings are social bodies, as well as spatial material arrangements that mediate relationships between individuals and affect their behaviours (Lawson, 2001). To explain the

effect of the built environment on the professionals' behaviours, the scholarship related to the environmental psychology is informative, as it focuses on the interaction between humans and their surroundings including their social settings and built environments. Proshansky (1970) has written in this field, and stressed that buildings are both social and physical phenomena, influencing the interactions between the people who use them, and also influencing the ways people behave within them.

In summary therefore, an organization can influence people's behaviours both physically, through its layout, and through its contextual rationalities and discourses embedded in its different spaces.

Conclusion

The clinical research which has typically dominated the field of pain management, has tended to focus on a limited set of factors with a limited regard for contextual influences. Such studies often blame nurses for unimproved pain management outcomes. Through a mainly qualitative case study design and the adoption of post-structural approach, this study demonstrates that while there is indeed a lack of pain assessment, intervention, and documentation practices among nurses in surgical wards, intertwined contextual factors have a profound effect in bringing about this limited engagement.

A set of socio-cultural and organizational factors played a role in limiting the potential for nurses to be involved in patients' pain assessment and management. Nurses were, therefore, discouraged from moving from simple observation to productive stages of knowing, analysis, and decision making.

The socio-cultural factors that were captured were: sexual surveillance, an inferior public view of nurses, patriarchal ideas, and the use of personal influence (*wasta*). Organizational factors included: hierarchical observations, fear of punishment, reinforcement of nursing subordination in relationships with other health professionals, perceptions of low staffing and high workload, and social hierarchies, such as rank.

Among all the influencing factors, socio-cultural factors appeared to exert the greatest effect. For example, nurses' responses to organizational policies were highly determined by more dominant cultural constructions and norms, so that if a certain policy was not in line with culturally accepted norms, the policy was often ignored. In addition, socio-cultural factors seem to have been a more powerful influence on nurses' practices than religious beliefs, which did not seem to play a role in the majority of nurses' practices and attitudes.

Contextual factors displayed an influence through a set of power mechanisms that were mainly based on discipline. Disciplinary mechanisms played a substantial role in: limiting the ability of nurses to involve themselves in patients' pain management and in accessing their bodies; undermining nursing professionalism by impacting upon autonomy and self-regulation; and reducing patients' willingness to communicate pain to and be cared for by professionals of different gender.

Although both socio-cultural and organizational factors displayed effects via disciplinary power, there were differences in the ways this power was applied and the extent of the influence it had. Socio-cultural factors exerted

disciplinary power on a collective basis over all females and males regardless of their positions in the hospitals. That is, the socio-cultural factors displayed their influences mainly when individuals interacted with others of the opposite gender. This influence was less when participants interacted with others of same gender, but similar patterns of behaviour were evident and interactions were dominated by models of professional hierarchy rather than gender hierarchy.

However, organizational factors exerted their influence on professionals more than patients, and this influence was directed at those who were of lower status in the hierarchy of the organization, specifically nurses.

Another difference identified between socio-cultural and organizational power and influence is the extent to which disciplinary consequences and penalties could be avoided. While the organizational penalties, such as being berated by the head of the department and a black mark being applied to a professional record, or salary deduction, could be avoided by applying a socially constructed phenomenon, such as the use of personal influence (*wasta*); socio-cultural penalties, such as shame and misinterpretation seem more difficult to circumvent since they, unlike organizational penalties, are not applied by one particular group of individuals, but by the whole society.

This study also reported that socio-cultural factors exert an influence on individuals' consciousness and practices, and this might explain why socio-cultural factors override organizational influences at times. Organizational factors influenced some individuals' practices but not their beliefs about certain types of practices.

Finally, this study points to an alternative way of exploring and explaining the behaviours of nurses in pain management. Considering contextual factors revealed the challenges for nursing in Jordan in finding a way to develop from a semi-profession to a full profession, particularly in their relations with the medical profession.

Limitations and reflections on study theory and setting

After my research journey, if I had the chance to undertake another piece of research, I would like to consider these four points: Firstly, it would be useful to investigate other theories in the social research further. This is because Foucault's insights regarding power could not explain the persistent subordination and docility of nurses and patients to their cultural context. This might be because Foucauldian insights were designed to study "postmodern societies", where cultural issues such as gender and patriarchy might assert less power over human illness and professional experiences. Gramsci's insights of cultural hegemony and the potential influence of ideology on people's practices seem to be better able to explain this persistent subordination.

Secondly, it would be useful to include other hospitals, and ideally to have more time. This study was conducted in a part of Jordan where the majority of patients were indigenous Jordanian villagers. The findings might be different if the study was conducted in a more urban environment, especially one where the majority of the population are Jordanian Palestinians, and people of wealthier classes. This is because some studies show that patients' lifestyle and socio-economic status might influence both nurses' behaviours

and decisions (Wilson, 2009; McCaffery, et al., 1992), and patients' pain responses. Different findings may therefore have emerged in an urban setting, especially in regard to the norms related to female-male relationships or stoicism.

Thirdly, private hospitals were not investigated because the two studied hospitals were already selected, and studying one more private hospital, with two wards, would have enlarged the sample to an unmanageable level within the timescale of a PhD. Thus, a study to investigate the influence of the organizational system existent within private hospitals might be a useful addition, especially as relatives and patients interviewed often made comparisons between the services presented in private hospitals and non-private hospitals. The system of recruitment in private hospitals means that staff can be dismissed if they do not comply with set performance standards. Such a threat might push nurses beyond their cultural norms, for example those related to different gender interactions, to adhere to private hospitals' standards of performance and work. One way of exploring this could be by using Marxist insights about economic interdependency to examine the effect of the economic relationship on the employer and the employees' behaviours when the employer has, or does not have, the ability to dismiss employees.

Fourthly, the research could be extended to include assistant nurses. Assistant nurses were excluded from the research because it was understood that they did not have a role in patients' pain management. However, because of the absence of a clear and distinct job description for either

registered staff nurses or assistant nurses, the latter often carried out some of the duties of staff nurses, and this meant that they were more involved in patient care than anticipated. The duties assistant nurses were involved in included administering painkillers because of ‘inappropriate delegation’ by staff nurses (Chapter Six; Section One; Subsection 1.2).

Finally, it should be acknowledged that this study has been conducted in a setting where I had captured observations of people suffering pain, and some of them complained of pain until the last moment before their death. Such an experience full of charged moments was an undeniable influence over my view of events, as I am passionate about good pain management, and often felt patients had been let down by poor pain management. However, I feel that I did take appropriate steps to assure trustworthiness of the captured data by not intervening even when this was emotionally and ethically challenging.

With these limitations acknowledged however, this study has still made an important contribution to the nursing and pain management literature.

Significance and contribution of the study

1. This study makes an empirical, mainly qualitative contribution to the body of nursing research in Jordan and the Middle East regarding factors that influence postoperative pain management. It fills a gap resulting from a lack of qualitative pain studies in Jordan and other Arab countries.

2. This study showed that consideration of the influence of organizational and socio-cultural factors has not been a feature of mainstream pain research, but that this is a very important dimension.
3. This study established that the majority of Foucauldian post-structural insights can be used to understand clinical phenomena in non-modern communities, specifically, tribal based communities.
4. Considering organizations and society from a post-structuralist perspective, drawing on Foucault, is a distinctive contribution to Jordanian and Middle Eastern nursing research.
5. This study showed that cultural factors dominate and override nursing professionalism and organizational factors. This is particularly important because it suggests that a Western based training might not translate well to a different cultural context. This study established that socio-cultural factors affect pain management and thus, not all clinical advances, evidenced-based research, and guidelines in pain management can transfer, without modifications, to all cultures.
6. This research makes a theoretical contribution by utilising Foucault and Gramsci's theoretical frameworks in a gendered analysis. Both of these social theorists/philosophers have not included gender within their work, so this study extends their theoretical frameworks.
7. Although this study was conducted in Jordan, this ethnographic multiple case study of pain management argues for a contextual theory of pain management, one which considers organizational and cultural factors.

Recommendations

1. Modifying the timing of writing painkillers orders for surgical patients

One of the aims of any research is to suggest feasible and applicable recommendations which might help improve situations where change is needed. In this research, it was revealed that postoperative patients are not given painkillers in some cases because nurses are waiting for doctors' orders from the theatre. A suggestion that might overcome this issue is to write orders relating to painkillers on patients' medication sheets, which are usually not attached to their medical records, prior to surgery. This might spare patients the pain they experience while waiting for doctors to write, and return orders to the ward, postoperatively.

2. Revising hierarchical observations

According to interviews with nurses and patients hierarchical observations diverted nurses' focus from patients' complaints and patient centred care to other areas such as the cleanliness of the wards, or the tidiness of their records. Thus, it is highly recommended to revise the object of the observations to include asking patients about their pain experiences, especially in light of the problems with pain management that emerged in this study. Focusing also on the documented pain practices and introducing sheets that include pain as the fifth vital sign might prompt nurses to assess patients' pain.

Developing a detailed and systematic set of organizational expectations regarding nurses' roles in pain management is recommended. Both studied

hospitals had only constructed and inspected, mostly through hierarchical observations, what their expectations were of nurses, including legal restrictions. Such expectations were limited, for example, to preventing crossing the medication administration policies, and required lengthy documentation, reinforcing nurses' feeling of being burdened. A reward system for good pain management could help to establish and reinforce such care.

It is recommended that the content of hierarchical observations is modified to include at least a minimal level of expectation of pain management. As a first step, pain can be included as a criterion in inspectors' profiles to be checked during inspection rounds, and can be included on sheets of vital signs.

3. Visiting times

It is recommended that the visiting hours and the numbers of visitors permitted on wards is organized in such a way as to take into account the resulting psychological effect on patients, and the requirements of professionals to do their jobs. To do this, the development of a sensitive visiting policy negotiated between staff and patients to suit both parties' needs is suggested.

4. Culturally compatible policies and curriculum

As shown in the findings and discussion chapters, socio-cultural factors were dominant on all participants involved in pain management: nurses, doctors, patients, and relatives. In terms of the applicability of any plan to improve pain management, or any adopted pain management protocol or

guideline, it is recommended that there is a consideration of the cultural restrictions set by the cultural discourse. It is further recommended that these factors are considered in relation to the nursing education curricula, in addition to policies related to the recruitment system of male and female nurses in different wards.

Administration policies failed to prompt nurses to treat males and female patients similarly, simply because “social norm[s] cannot be wiped out as if it was a stain on the carpet” (Schlumberger, 2002: 243). Thus, a recommendation of professional segregation on the basis of gender in different departments might induce a partial solution to some of the issues that emerged. An alternative suggestion would be increasing the numbers of male nurses on male wards. Briefly, if patients are segregated according to their gender in two surgical wards in each hospital, female nurses are suggested to be recruited for female patients’ wards, and male nurses for male patients’ wards. This solution might solve the issues related to interaction of nurses and patients of opposite genders, but might not decrease the problem of a lack of pain assessment and management since these practices were also witnessed among female nurses in female patients’ wards.

A university pain curriculum that takes into account both the theoretical and clinical aspects of pain management approaches, as well as their cultural dimensions is needed. It is recommended that the suggested curriculum highlights the role of nursing in pain management and what is expected of nurses by both patients and other professionals. An example of a suggested

curriculum is the curriculum on pain for schools of nursing that was published by the International Association for the Study of Pain (IASP) (2006), and that suggested by Hunter et al (2008), but with modifications to correspond to the socio-cultural norms and traditions.

5. Using mass media to modify the public view of nurses

Mass media is a factor that prompted patients to hide information about pain from nurses. Modifying such practices requires strategic work from nurses and it might take a relatively long time to fix their image on the public level in Jordan. Kalisch, Begeny & Neumann (2007), and Kalisch and Kalisch (1983) and many others have suggested many steps to improve nurses' image in the mass media such as: contacting the decision makers in the media; disseminating nursing conferences, broadcasting academic and clinical achievements more frequently on television; and mobilising an active movement against all images that impact badly upon the nursing image, especially those which depict nurses as "sex objects".

Concluding remarks

This thesis suggested that anyone placed within contexts such as those which were studied and analysed in this research, might behave similarly to the nurses in the hospitals observed. However, patients experiencing pain after surgery in Jordan clearly have a right to expect their pain to be managed. Enacting the suggested recommendations would be the first step to providing a more appropriate regime of pain relief after surgery, one of which nurses can be proud.

References

- Abushaikha, L. A. (2007). Methods of coping with labor pain used by Jordanian women. *Journal of Transcultural Nursing*, 18(1), 35-40.
- AbuAlRub, R. F. & Al-Asmar, A. H. (2011). Physical Violence in the Workplace Among Jordanian Hospital Nurses. *Journal of Transcultural Nursing* 22(2), 157-165.
- Agger, B. (1991). Critical theory, poststructuralism, postmodernism: Their sociological relevance. *Annual Review of Sociology*, 17, 105-131.
- Ahmad, M. M., & Alasad, J. A. (2007). Patients' preferences for nurses' gender in Jordan. *Int J Nurs Pract*, 13(4), 237-242.
- Akbas, M., & Oztunc, G. (2008). Examination of knowledge about and nursing interventions for the care of patients in pain of nurses who work at Cukurova University Medical Faculty Balcali Hospital. *Pain Management Nursing*, 9(3), 88-95.
- Alghad Newspaper (2011, March 6). 1.2 مليون أردني غير مشمولين بالتأمين الصحي. Alghad Newspaper. Amman, Alghad.
- Al Samaraee, A., Rhind, G., Saleh, U., & Bhattacharya, V. (2010). Factors contributing to poor post-operative abdominal pain management in adult patients: A review. *Surgeon-Journal of the Royal Colleges of Surgeons of Edinburgh and Ireland*, 8(3), 151-158.
- Al-Hassan, M., Alkhalil, M. S., & Al Ma'aitah, R. (1999). Jordanian nurses' roles in the management of postoperative pain in the postanesthesia care unit. *Journal of PeriAnesthesia Nursing*, 14(6), 384-389.
- Al-Hassan, M., & Hweidi, I. (2004). The perceived needs of Jordanian families of hospitalized, critically ill patients. *International Journal of Nursing Practice*, 10, 64-71.
- Al-Hassan, M., & Omran, S. M. (2005). The effects of health beliefs on health care-seeking decisions of Jordanian patients with myocardial infarction symptoms. *International Journal of Nursing Practice*, 11, 13-20.
- Al-Ma'aitah, R., & Garaibeh, M. (2000). Perception of Jordanian male nursing students about caring for children in the pediatric units after graduation. *Journal of Pediatric Nursing*, 15(3), 198-203.

Al-Makhamreh, S. (2005). *Social work as an emerging profession in the Middle East : An ethnographic case study of Jordanian hospital social work*. [PhD Thesis]. University of Warwick, Coventry.

Al-Makhamreh, S. S., & Lewando-Hundt, G. (2008). Researching 'at Home' as an Insider/Outsider: Gender and culture in an ethnographic study of social work practice in an Arab society. *Qualitative Social Work*, 7(1), 9-23.

Allen, D. (1997). The nursing-medical boundary: A negotiated order?. *Sociology of Health & Illness*, 19(4), 498-520.

Aloisi, A. M. (2003). Gonadal hormones and sex differences in pain reactivity. *The Clinical Journal of Pain*, 19, 168-174.

Apfelbaum, J., Chen, C., Metha, S., & Gan, T. (2003). Postoperative pain experience: Results from a national survey suggest postoperative pain continues to be undermanaged. *Anesth Analg*, 97, 534-540.

Aubrun, F., Salvi, N., Coriat, P., & Riou, B. (2005). Sex- and age-related differences in morphine requirements for postoperative pain relief. *Anesthesiology*, 103(1), 156-160.

Avis, M. (1994). Choice cuts: An exploratory study of patients' views about participation in decision-making in a day surgery unit. *International Journal of Nursing Studies*, 31(3), 289-298.

Bailey, K. D. (1982). *Methods of social research* (2nd ed.). New York: Free Press.

Bandolier. (2007). The Oxford Pain Internet Site. 31-5-2009, from <http://www.medicine.ox.ac.uk/bandolier/booth/painpag/index2.html>

Bates, T. R. (1975). Gramsci and theory of hegemony. *Journal of the History of Ideas*, 36(2), 351-366.

Baudrillard, J. (1983). *Simulation*. New York: Semiotext(e).

Beauchamp, T. L., & Childress, J. F. (2001). *Principles of biomedical ethics* (5th ed.). New York: Oxford University Press.

Bendelow, G. (1993). Pain perceptions, emotions and gender. *Sociology of Health & Illness*, 15(3), 273-294.

Bendelow, G., & Williams, S. (1995). Pain and the Mind-body dualism: A sociological approach. *Body and Society*, 1, 83-103.

Blaxter, L., Hughes, C., & Tight, M. (2006). *How to research* (3rd ed.). Berkshire: Open University Press.

- Brand, L. A. (1998). Women and the state in Jordan: Inclusion or exclusion? In Y. Y. Haddad & J. L. Esposito (Eds.), *Islam, gender and social change* (pp. 100-123). New York: Oxford University Press, Inc.
- Brekke, M., Hjortdahl, P., & Kvien, T. (2002). Severity of musculoskeletal pain: Relations to socioeconomic inequality. *Social Science & Medicine*, 54, 221-228.
- Brekke, M., Hjortdahl, p., Thelle, D., & Kvien, T. (1999). Disease activity and severity in patients with rheumatoid arthritis: Relations to socioeconomic inequality. *Social Science and Medicine*, 48, 1743-1750.
- Brennan, F., Carr, D. B., & Cousins, M. (2007). Pain management: A fundamental human right. *Anesthesia & Analgesia*, 105(1), 205-221.
- Briggs, M., & Dean, K. L. (1998). A qualitative analysis of the nursing documentation of post-operative pain management. *Journal of Clinical Nursing*, 7(2), 155-163.
- Brockopp, D. Y., Brockopp, G., Warden, S., Wilson, J., Carpenter, J. S., & Vandever, B. (1998). Barriers to change: A pain management project. *International Journal of Nursing Studies*, 35(4), 226-232.
- Broekmans, S., Vanderschueren, S., Morlion, B., Kumar, A., & Evers, G. (2004). Nurses' attitudes toward pain treatment with opioids: A survey in a Belgian university hospital. *International Journal of Nursing Studies*, 41(2), 183-189.
- Brown, A. D., & Humphreys, M. (2006). Organizational identity and place: A discursive exploration of hegemony and resistance. *Journal of Management Studies*, 43(2), 231-257.
- Brown, C., & Seddon, J. (1996). Nurses, doctors and the body of the patient: Medical dominance revisited. *Nursing Inquiry*, 3, 30-35.
- Bryman, A. (2008). *Social research methods* (3rd ed.). New York: Oxford University Press Inc.
- Bucknall, T., Manias, E., & Botti, M. (2007). Nurses' reassessment of postoperative pain after analgesic administration. *Clinical Journal of Pain*, 23(1), 1-7.
- Burgess, D. J., Crowley-Matoka, M., Phelan, S., Dovidio, J. F., Kerns, R., Roth, C., et al. (2008). Patient race and physicians' decisions to prescribe opioids for chronic low back pain. *Social Science & Medicine*, 67(11), 1852-1860.
- Burgess, R. (1984). *In the field: An introduction to field research*. London: Allen & Unwin.

Buyukyilmaz, F. E., & Asti, T. (2010). Postoperative pain characteristics in Turkish orthopedic patients. *Pain Management Nursing*, 11(2), 76-84.

Calderone, K. L. (1990). The influence of gender on the frequency of pain and sedative medication administered to postoperative patients. *Sex Roles*, 23(11-12), 713-725.

Campbell-heider, N., & Pollock, D. (1987). Barriers to physician-nurse collegiality: An anthropological perspective. *Social Science & Medicine*, 25(5), 421-425.

Carper, B. (1978). Fundamental patterns of knowing in nursing. In J. W. Kenney (Ed.), *Philosophical and theoretical perspectives for advanced nursing practice* (3rd ed., pp. 22-30). Sudbury, Massachusetts: Jones and Bartlett Publishers.

Carr, E. (2009). Barriers to effective pain management. *eprints.bournemouth.ac.uk*. 28-10-2010, from http://eprints.bournemouth.ac.uk/11565/1/Eloise's_Periop_pain_chapter_2008.pdf

Cheek, J. (2000). *Postmodern and poststructural approaches to nursing research*. Thousand Oaks, London, New Delhi: Sage Publications. Inc.

Cheek, J., & Porter, S. (1997). Reviewing Foucault: Possibilities and problems for nursing and health care. *Nursing Inquiry*, 4, 108-119.

Chiu, L. H., Trinca, J., Lim, L. M., & Tuazon, J. A. (2003). A study to evaluate the pain knowledge of two sub-populations of final year nursing students: Australia and Philippines. *Journal of Advanced Nursing*, 41(1), 99-108.

Choiniere, M., Melzack, R., Girard, N., Rondeau, J., & Paquin, M. J. (1990). Comparisons between patients and nurses assessment of pain and medication efficacy in severe burn injuries. *Pain*, 40(2), 143-152.

Clabo, L. (2008). An ethnography of pain assessment and the role of social context on two postoperative units. *J Adv Nurs*, 61(5), 531-539.

Clarke, E., French, B., Bilodeau, M., Capasso, C., Edwards, A., & Empoliti, J. (1996). Pain management knowledge attitudes and clinical practice: The impact of nurses' characteristics and education. *Journal of Pain and Symptom Management*, 11(1), 18-31.

Closs, S. J. (1996). Pain and elderly patients: A survey of nurses' knowledge and experiences. *Journal of Advanced Nursing*, 23(2), 237-242.

Cohen, A., & Court, D. (2003). Ethnography and case study: A comparative analysis. *Academic Exchange Quarterly*. 16-3-2009, from http://www.accessmylibrary.com/coms2002/summary_0286-19885358_ITM

- Cohen, F. L. (1980). Postsurgical pain relief: Patients' status and nurses' medication choices. *Pain*, 9, 265–274.
- Coll, A. M., & Ameen, J. (2006). Profiles of pain after day surgery: Patients' experiences of three different operation types. *Journal of Advanced Nursing*, 53(2), 178–187.
- Coombs, M. (2003). Power and conflict in intensive care clinical decision making. *Intensive and Critical Care Nursing*, 19, 125-135.
- Crehan, K. (2002). *Gramsci, culture, and anthropology*. Berkeley, Los Angeles: University of California Press.
- Crowe, M. (2000). The nurse-patient relationship: A consideration of its discursive context. *Journal of Advanced Nursing*, 31(4), 962-967.
- Crowe, M. (1998). The power of the word: Some post-structural considerations of qualitative approaches in nursing research. *Journal of Advanced Nursing*, 28(2), 339-344.
- Cummings, S. H. (1995). Attila the hun versus Attila the hen: Gender socialization of the American nurse. *Nurs Admin Q*, 19(2), 19-29.
- Cunningham, R. B., & Sarayrah, Y. K. (1994). Taming Wasta to achieve development. *Arab Studies Quarterly*, 16(3), 29-39.
- Daibes, M. (2008). *What are patients' factors that may affect their perception and expression of pain? A review and a critique of the literature*. [Unpublished MA dissertation]. University of Warwick, Coventry, UK.
- Daiski, I. (2004). Changing nurses' disempowering relationship patterns. *Journal of Advanced Nursing*, 48(1), 43-50.
- Dalton, J. A., Carlson, J., Blau, W., Lindley, C., Greer, S. M., & Youngblood, R. (2001). Documentation of pain assessment and treatment: How are we doing?. *Pain Manag Nurs*, 2(2), 54-64.
- Daly, J. M. (1999). Visitation facilitation. In G. Bulechek & J. McCloskey (Eds.), *Nursing interventions: Effective nursing treatments* (3rd ed., pp. 650-657). Philadelphia, Pennsylvania: W.B. Saunders Company.
- Danaher, G., Schirato, T., & Webb, J. (2000). *Understanding Foucault*. Australia: Sage Publications.
- Darlington, Y., & Scott, D. (2002). *Qualitative research in practice: Stories from the field*. Philadelphia, USA: Open University Press.

Davidhizar, R., & Giger, J. N. (2004). A review of the literature on care of clients in pain who are culturally diverse. *Int Nurs Rev*, 51(1), 47-55.

Davies, B. (1989). The discursive production of the male-female dualism in school settings. *Oxford Review of Education*, 15(3), 229-241.

Davies, K. (2003). The body and doing gender: The relations between doctors and nurses in hospital work. *Sociology of Health & Illness*, 25(7), 720-742.

Davoudi, N., Afsharzadeh, P., Mohammadalizadeh, S., & Haghdooost, A. A. (2008). A comparison of patients' and nurses' assessments of pain intensity in patients with coronary artery disease. *International Journal of Nursing Practice*, 14(5), 347-356.

Dean, M. (1999). *Governmentality: Power and rule in modern society*. London, Thousands Oaks, New Delhi: Sage Publications.

Denzin, N. K., & Lincoln, Y. S. (2005). Methods of collecting and analyzing empirical materials. In N. K. Denzin & Y. S. Lincoln (Eds.), *The SAGE handbook of qualitative research* (3rd ed., pp. 641-649). Thousand Oaks, London, New Delhi: Sage Publications, Inc.

Denzin, N. K., & Lincoln, Y. S. (Eds.). (1994). *The SAGE handbook of qualitative research*. California: Sage Publications.

Department of Health. (2009). *Putting people at the heart of care: The vision for public and patient experience and engagement in health and social care*. London, UK.

Dickens, C., McGowan, L., & Dale, S. (2003). Impact of depression on experimental pain perception: A systematic review of the literature with Meta-analysis. *Psychosomatic Medicine*, 65, 369-375.

Doering, L. (1992). Power and knowledge in nursing: A feminist poststructuralist view. *Adv Nurs Sci*, 14(4), 24-33.

Donovan, M., Dillon, P., & McGuire, L. (1987). Incidence and characteristics of pain in a sample of medical-surgical inpatients. *Pain*, 30, 69-78.

Dougherty, D. M. (1999). Surveillance. In G. M. Bulechek & J. C. McCloskey (Eds.), *Nursing interventions: Effective nursing treatments* (3rd ed.). Philadelphia, PA: Saunders.

Dudley, S. R., & Holm, K. (1984). Assessment of the pain experience in relation to selected nurse characteristics. *Pain*, 18(2), 179-186.

El Azhary Sonbol, A. (2003). *Women of Jordan: Islam, labor, and the law* (1st. ed.): Syracuse University Press.

Ene, K. W., Nordberg, G., Bergh, I., Johansson, F. G., & Sjostrom, B. (2008). Postoperative pain management - The influence of surgical ward nurses. *Journal of Clinical Nursing*, 17(15), 2042-2050.

Epps, C. D., Ware, L. J., & Packard, A. (2008). Ethnic wait time differences in analgesic administration in the Emergency Department. *Pain Management Nursing*, 9(1), 26-32.

Fagerhaugh, S., & Strauss, A. (1977). *Politics of pain management: Staff-patient interaction*. California: Addison-Wesley Pub.

Faherty, B. S., & Grier, M. R. (1984). Analgesic medication for elderly people post-surgery. *Nursing Research*, 33(6), 369-372.

Fainzang, S. (2005). When doctors and patients lie to each other: Lying and power within the doctor-patient relationship. In E. van-Dongen & S. Fainzang (Eds.), *Lying and Illness: Power and performance* (pp. 36-55). Amsterdam: Het Spinhuis, Amsterdam.

Fairhurst, G. T., & Putnam, L. (2004). Organizations as discursive constructions. *Communication Theory*, 14(1), 5-26.

Faith, K. (1994). Resistance: Lessons from Foucault and Feminism. In H. L. Radtke & H. J. Stam (Eds.), *Power/Gender: Social relations in theory* (1st ed.). London, Thousands Oaks, New Delhi: Sage Publications Ltd.

Feagin, J. R., Orum, A. M., & Sjoberg, G. (1991). Introduction: The nature of the case study. In J. R. Feagin, A. M. Orum & G. Sjoberg (Eds.), *A case for the case study* (pp. 290). Chapel Hill, North Carolina: University of North Carolina Press.

Ferrell, B. R., & McCaffery, M. (2008). Knowledge and Attitudes Survey Regarding Pain. 10-4-2009, from <http://prc.coh.org/Knowledge%20Attitude%20Survey%20-%20updated%205-08.pdf>

Ferrell, B. R., McGuire, D. B., & Donovan, M. I. (1993). Knowledge and beliefs regarding pain in a sample of nursing faculty. *J Prof Nurs*, 9(2), 79-88.

Fielding, N., & Lee, R. M. (1998). *Computer analysis and qualitative research*. London, Thousands Oaks, New Delhi: Sage Publications.

Fielding, R. (1994). Discrepancies between patient and nurse perceptions of post-operative pain: shortcomings in pain control. *J Hong Kong Med Assoc*, 46(2), 142-146.

Forster, N. (1994). The analysis of company documentation. In C. Cassell & G. Symon (Eds.), *Qualitative methods in organizational research* (pp. 147-166). London, Thousand Oaks, New Delhi: Sage Publication Inc.

Foss, C., & Sundby, J. (2003). The construction of the gendered patient: Hospital staff's attitudes to female and male patients. *Patient Education and Counseling*, 49(1), 45-52.

Foucault, M. (1972). *The archaeology of knowledge*. (A. Sheridan, Trans.). London: Routledge.

Foucault, M. (1975). *The Birth of the Clinic*. New York: Vintage Books.

Foucault, M. (1977). *Discipline and punish: The birth of the prison*. (A. Sheridan, Trans.). London: Penguin Books.

Foucault, M. (1980). *Power/Knowledge: Selected interviews and other writings, 1972-1977*. (C. Gordon, L. Marshall, J. Mepham & K. Soper, Trans.). New York: Pantheon.

Foucault, M. (1982a). The subject and power. In H. Dreyfus & P. Rainbow (Eds.), *Michel Foucault: Beyond Structuralism and Hermeneutics* (pp. 208-226). New York: Harvester Wheatsheaf.

Foucault, M. (1982b). The subject and power. *Critical Inquiry*, 8(4), 777-795.

Foucault, M. (1991). Governmentality. In G. Burchell, C. Gordon & P. Miller (Eds.), *The Foucault effect: Studies in governmentality with two lectures by and interview with Micheal Foucault* (pp. 87-104). Hertfordshire: Harvester Wheatsheaf.

Foucault, M. (1994). *Micheal Foucault: Power, essential works of Foucault 1954-1984*. (R. Hurley, Trans. Vol. Three). London: Penguin Books.

Foucault, M. (1998). *The will to knoweldge: The history of sexuality* (R. Hurley, Trans. Vol. One). London: Penguin Books Ltd.

Freidson, E. (1970). *Profession of medicine: A study of the sociology of applied knowledge*. Chicago: Chicago Press.

Fukuyama, F. (1999). *The great disruption: Human nature and the reconstitution of social order*. London: Profile Books.

Gagliese, L., Weizblit, N., Ellis, W., & Chan, V. W. S. (2005). The measurement of postoperative pain: A comparison of intensity scales in younger and older surgical patients. *Pain*, 117(3), 412-420.

- Garrett, A. (1965). *Interviewing: Its principles and methods*. New York: Family Service Association of America.
- Gavey, N. (1989). Feminist poststructuralism and discourse analysis - Contributions to feminist psychology. *Psychology of Women Quarterly*, 13(4), 459-475.
- Geertz, C. (1973). Thick description: Toward an interpretive theory of culture. In C. Geertz (Ed.), *The interpretation of cultures: Selected essays* (pp. 3-32). New York: Basic Books.
- Gelinas, C. (2007). Management of pain in cardiac surgery ICU patients: Have we improved over time? *Intensive Crit Care Nurs*, 23(5), 298-303.
- George, A. (2005). *Jordan: Living in the Crossfire*. London; New York: Zed Books.
- Gillham, B. (2000). *Case study research methods* (1st ed.). London, New York: Continuum.
- Girard, F., Chouinard, P., Boudreault, D., Poirier, C., Richard, C., Ruel, M., et al. (2006). Prevalence and impact of pain on the quality of life of lung transplant recipients: A prospective observational study. *Chest*, 130, 1535-1540.
- Gjerberg, E., & Kjolsrod, L. (2001). The doctor-nurse relationship: How easy is it to be a female doctor co-operating with a female nurse? *Social Science and Medicine*, 52, 189-202.
- Gjerde, P. F. (2004). Culture, power, and experience: Toward a person-centered cultural psychology. *Human Development*, 47(3), 138-157.
- Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Hawthorne, New York: Aldine de Gruyter.
- Goodrich, C. (2006). Students' and faculty members' knowledge and attitudes regarding pain management: A descriptive survey. *Journal of Nursing Education*, 45(3), 140-142.
- Gramke, H. F., de Rijke, J. M., van Kleef, M., Raps, F., Kessels, A. G. H., Peters, M. L., et al. (2007). The prevalence of postoperative pain in a cross-sectional group of patients after day-case surgery in a University Hospital. *Clinical Journal of Pain*, 23(6), 543-548.
- Gramsci, A. (2000). *The Antonio Gramsci reader: Selected writings 1916-1935* (1st ed.). New York: New York University Press.
- Gramsci, A. (2011). *Antonio Gramsci prison notebooks*. (J. Buttigieg, Trans. Vol. Three). New York: Columbia University Press.

- Greer, S. M., Dalton, J. A., Carlson, J., & Youngblood, R. (2001). Surgical patients' fear of addiction to pain medication: The effect of an educational program for clinicians. *Clinical Journal of Pain*, 17(2), 157-164.
- Griffiths, R. J., & Justin, D. M. (2006). Perioperative management of pain. *Surgery*, 24(10), 325-328.
- Grimen, H. (2009). Power, trust, and risk some reflections on an absent issue. *Medical Anthropology Quarterly*, 23(1), 16-33.
- Guillemin, M., & Gillam, L. (2004). Ethics, reflexivity, and "ethically important moments" in research. *Qualitative Inquiry*, 10(2), 261-280.
- Haddad, L., Kane, D., Rajacich, D., Cameron, S., & Al-Ma'aitah, R. (2004). A comparison of health practices of Canadian and Jordanian nursing students. *Public Health Nursing*, 21(1), 85-90.
- Haddad, Y. Y., & Esposito, J. L. (Eds.). (1998). *Islam, gender, and social change*. New York: Oxford University Press.
- Haljamae, H., & Stomberg, M. W. (2003). Postoperative pain management: Clinical practice is still not optimal. *Current Anaesthesia & Critical Care*, 14, 207-210.
- Hall, J. R., Neitz, M. J., & Battani, M. (2003). *Sociology on culture* (1st ed.). London, New York: Routledge.
- Hall, R. H. (1968). Professionalization and bureaucratization. *American Sociological Review*, 33(1), 92-104.
- Hallowell, N., Lawton, J., & Gregory, S. (Eds.). (2005). *Reflections on research :The realities of doing research in the social sciences*. Maidenhead: Open University Press.
- Hamers, J. P. H., van den Hout, M. A., Halfens, R. J. G., Abu-Saad, H. H., & Heijltjes, A. E. G. (1997). Differences in pain assessment and decisions regarding the administration of analgesics between novices, intermediates and experts in pediatric nursing. *International Journal of Nursing Studies*, 34(5), 325-334.
- Hamilton, J., & Edgar, L. (1992). A survey examining nurses' knowledge of pain control. *Journal of Pain and Symptom Management*, 7(1), 18-26.
- Hammersley, M., & Atkinson, P. (2007). *Ethnography: Principles in practice* (3rd ed.). New York: Routledge.
- Harper, P. (2006). No pain, no gain: Pain behaviour in the armed forces. *British Journal of Nursing*, 15(10), 548-551.

- Harper, P., Ersser, S., & Gobbi, M. (2007). How military nurses rationalize their postoperative pain assessment decisions. *Journal of Advanced Nursing*, 59(6), 601– 611.
- Harrison, A. (1991). Assessing patients' pain: Identifying reasons for error. *Journal of Advanced Nursing*, 16(9), 1018-1025.
- Haung, N., Cunningham, F., & Laurito, C. E. (2001). Can we do better with postoperative pain management? *The American Journal of Surgery*, 182, 440-448.
- Henderson, A. (1994). Power and knowledge in nursing practice: The contribution of Foucault. *Journal of Advanced Nursing*, 20, 935-939.
- Henneman, E. A. (1995). Nurse-physician collaboration: A poststructuralist view. *Journal of Advanced Nursing*, 22, 359-363.
- Herr, K., & Chen, P. (2009). Postoperative pain assessment with three intensity scales in Chinese elders. *Journal of Nursing Scholarship*, 41(3), 241-249.
- Hodes, J. R., & van Crombrughe, P. (1990). Nurse-physician relationships. *Nurs Manage*, 21(7), 73-75.
- Holloway, I., & Wheeler, S. (1995). Ethical issues in qualitative nursing research. *Nursing Ethics*, 2, 223-232.
- Hollway, W. (1994). Separation, integration and difference: Contradictions in a gender regime. In H. L. Radtke & H. J. Stam (Eds.), *Power/Gender: Social relations in theory and practice* (1st ed.). London, Thousands Oaks, New Delhi: Sage Publications.
- Holm, K., Cohen, F., Dudas, S., Medema, P. G., & Allen, B. L. (1989). Effect of personal pain experience on pain assessment. *Image J Nurs Sch*, 21(2), 72-75.
- Holmes, D., Prron, A. M., & Savoie, M. (2006). Governing therapy choices: Power/Knowledge in the treatment of progressive renal failure. *Philosophy, Ethics and Humanities in Medicine*, 1(12).
- Horbury, C., Henderson, A., & Bromley, B. (2005). Influences of patient behavior on clinical nurses' pain assessment: Implications for continuing education. *J Contin Educ Nurs*, 36(1), 18-24.
- Hunter, J., Watt-Watson, J., McGillion, M., Raman-Wilms, L., Cockburn, L., Lax, L., et al. (2008). An Interfaculty Pain Curriculum: Lessons learned from six years experience. *Pain*, 140(1), 74-86.
- Hutchings, K., & Weir, D. (2006). Guanxi and Wasta: A comparison. *Thunderbird International Business Review*, 48(1), 141-156.

Hutchinson, S. A., & Wilson, H. S. (2001). Grounded theory: The method. In P. L. Munhall & National League for Nursing (Eds.), *Nursing research: A qualitative perspective* (3rd ed., pp. 209-243). USA: Jones & Bartlett Publishers.

Idvall, E., Berg, K., Unosson, M., & Brudin, L. (2005). Differences between nurse and patient assessments on postoperative pain management in two hospitals. *Journal of Evaluation in Clinical Practice*, 11(5), 444-451.

Idvall, E., & Ehrenberg, A. (2002). Nursing documentation of postoperative pain management. *Journal of Clinical Nursing*, 11(6), 734-742.

International Association for The Study of Pain (IASP). (2006). Outline curriculum on pain for schools of nursing (2nd ed.). 20-9-2010, from <http://www.iasp-pain.org/AM/Template.cfm?Section=Home&Template=/CM/HTMLDisplay.cfm&ContentID=2320>

Jayadevappa, R., & Chhatre, S. (2011). Patient centered care: A conceptual model and review of the state of the art. *The Open Health Services and Policy Journal*, 4, 15-25.

JDoS. (2010). Jordan: Figures-2009. 9-3-2011, from http://www.dos.gov.jo/dos_home_a/main/jorfig/2009/jor_f_a.htm

JMoH. (2005). *National health strategy 2006-2010*. Amman: Jordan.

JMoH. (2011a). Health indicators: Health personnel by selected category and health sectors in Jordan. 13-5-2011, from http://www.moh.gov.jo/reports/headermain.jsp?print_parameter=yes&lang_parameter=english

JMoH. (2011b). Ministry of Health: Health sectors bodies. 10-3-2011, from http://www.moh.gov.jo/MOH/En/moh_hospitals.php

Jochum, T., Letzsch, A., Greiner, W., Wagner, G., Sauer, H., & Bar, K. J. (2006). Influence of antipsychotic medication on pain perception in schizophrenia. *Psychiatry Research*, 142, 151-156.

Johansson, E. E., Hamberg, K., Westman, G., & Lindgren, G. (1999). The meanings of pain: An exploration of women's descriptions of symptoms. *Social Science & Medicine*, 48, 1791-1802.

Johnson, G. I., & Briggs, P. (1994). Question-asking and verbal protocol techniques. In C. Cassell & G. Symon (Eds.), *Qualitative methods in organizational research* (pp. 55-71). London, Thousand Oaks, New Delhi: Sage Publications, Inc.

Johnson, M., & Webb, C. (1995). The power of social judgement: Struggle and negotiation in the nursing process. *Nurse Education Today*, 15, 83-89.

- Johnson, S. H. (1998). Introduction: Legal and regulatory issues in pain management. *The Journal of Law, Medicine & Ethics*, 26(4), 265-266.
- Kaki, A. M., Daghistani, M. F., & Msabeh, A. A. (2009). Nurses' knowledge of pharmacological measures on acute pain management in Western Saudi Arabia. *Saudi Medical Journal*, 30(2), 279-283.
- Kalisch, B. J., Begeny, S., & Neumann, S. (2007). The image of the nurse on the Internet. *Nursing Outlook*, 55(4), 182-188.
- Kalisch, B. J., & Kalisch, P. A. (1983). Improving the image of nursing. *American Journal of Nursing*, 83(1), 48-52.
- Kalisch, P. A., & Kalisch, B. J. (1986). A comparative-analysis of nurse and physician characters in the entertainment media. *Journal of Advanced Nursing*, 11(2), 179-195.
- Kappesser, J., Williams, A., & Prkachin, K. M. (2006). Testing two accounts of pain underestimation. *Pain*, 124(1-2), 109-116.
- Karadag, A., Hisar, F., & Elbas, N. O. (2007). The level of professionalism among nurses in Turkey. *Journal of Nursing Scholarship*, 39(4), 371-374.
- Kastanias, P., Denny, K., Robinson, S., Sabo, K., & Snaith, K. (2009). What do adult surgical patients really want to know about pain and pain management? *Pain Management Nursing*, 10(1), 22-31.
- Kenny, D., & Adamson, B. (1992). Medicine and the health professions: Issues of dominance, autonomy and authority. *Aust Health Rev*, 15(3), 319-334.
- Ketovuori, H. (1987). Nurses' and patients' conceptions of wound pain and the administration of analgesics. *J Pain Symptom Manage*, 2(4), 213-218.
- Kettunen, T., Poskiparta, M., & Gerlander, M. (2002). Nurse-patient power relationship: Preliminary evidence of patients' power messages. *Patient Education and Counseling*, 47, 101-113.
- Kim, H. S., Schwartz-Barcott, D., Tracy, S. M., Fortin, J. D., & Sjostrom, B. (2005). Strategies of pain assessment used by nurses on surgical units. *Pain Manag Nurs*, 6(1), 3-9.
- King, N. (1994). The qualitative research interview. In C. Cassell & G. Symon (Eds.), *Qualitative methods in organizational research*. London, Thousand Oaks, New Delhi: Sage Publications Inc.
- Kocher, K. M., & Thomas, G. W. (1994). Retaining army nurses: A longitudinal model. *Research in Nursing & Health*, 17, 59-65.

- Krouse, R. S., Easson, A. L., & Angelos, P. (2003). Ethical considerations and barriers to research in surgical palliative care. *Journal of American College of Surgeons*, 196(3), 469-474.
- Kurtz, S. (1989). *The art of unknowing: Dimensions of openness in analytic therapy*. Northvale, NJ: Aronson.
- Latimer, M. A., Johnston, C. C., Ritchie, J. A., Clarke, S. P., & Gilin, D. (2009). Factors affecting delivery of evidence-based procedural pain care in hospitalized neonates. *Jognn-Journal of Obstetric Gynecologic and Neonatal Nursing*, 38(2), 182-194.
- Lawson, B. (2001). *The language of space*. Oxford, Burlington: Architectural Press.
- Lawton, J. (2001). Gaining and maintaining consent: Ethical concerns raised in a study of dying patients. *Qualitative Health Research*, 11, 693-705.
- Li, L., Liu, X. Q., & Herr, K. (2007). Postoperative pain intensity assessment: A comparison of four scales in Chinese adults. *Pain Medicine*, 8(3), 223-234.
- Library of Congress Country Studies. (1989). Religion in Jordan - Ethnicity and Language. 9-3-2011, from http://atheism.about.com/library/FAQs/islam/countries/bl_JordanEthnicity.htm, from <http://atheism.about.com/gi/dynamic/offsite.htm?site=http://lcweb2.loc.gov/frd/cs/cshome.html>
- Lincoln, Y., & Guba, E. (1985). *Naturalistic inquiry*. California, London, New Delhi: Sage Publications, Inc.
- Lord, B., Cui, J., & Kelly, A. M. (2009). The impact of patient sex on paramedic pain management in the prehospital setting. *American Journal of Emergency Medicine*, 27(5), 525-529.
- Lui, L. Y., So, W. K., & Fong, D. Y. (2008). Knowledge and attitudes regarding pain management among nurses in Hong Kong medical units. *Journal of Clinical Nursing*, 17(15), 2014-2021.
- MacKay, R. C., Matsuno, K., & Mulligan, J. (1991). Communication problems between doctors and nurses. *Quality Assurance in Health Care*, 3(1), 11-19.
- Maier, C., Nestler, N., Richter, H., Hardinghaus, W., Pogatzki-Zahn, E., Zenz, M., et al. (2010). The quality of pain management in German hospitals. *Deutsches Arzteblatt International*, 107(36), 607-U614.

- Mangione, M. P., & Crowley-Matoka, M. (2008). Improving pain management communication: How patients understand the terms "Opioid" and "Narcotic". *Journal of General Internal Medicine*, 23(9), 1336-1338.
- Manias, E., Botti, M., & Bucknall, T. (2002). Observation of pain assessment and management: The complexities of clinical practice. *Journal of Clinical Nursing*, 11(6), 724-733.
- Manias, E., Bucknall, T., & Botti, M. (2005). Nurses' strategies for managing pain in the postoperative setting. *Pain Manag Nurs*, 6(1), 18-29.
- Manias, E., & Street, A. (2001a). Nurse-doctor interactions during critical care ward rounds. *Journal of Clinical Nursing*, 10(4), 442-450.
- Manias, E., & Street, A. (2001b). The interplay of knowledge and decision making between nurses and doctors in critical care. *International Journal of Nursing Studies*, 38(2), 129-140.
- Marks, R., & Sachar, M. (1973). Undertreatment of medical inpatients with narcotic analgesics. *Annals of Internal Medicine*, 78, 173-181.
- Mason, J. (2002). *Qualitative researching* (2nd ed.). London: Sage Publications.
- May, C. (1992). Nursing work, nurses' knowledge, and the subjectification of the patient. *Sociology of Health & Illness*, 14(4), 472-487.
- May, T. (1995). The basis and limits of physician authority - A reply to critics. *Journal of Medical Ethics*, 21(3), 170-173.
- Mays, N., & Pope, C. (2006). Quality in qualitative health research. In C. Pope & N. Mays (Eds.), *Qualitative research in health care* (3rd ed., pp. 82-101). Oxford: Blackwell Publishing LTD.
- McCaffery, M. (1979). *Nursing management of the patient with pain*. Philadelphia: J.B. Lippincott.
- McCaffery, M., & Ferrell, B. R. (1991). Patient age: Does it affect your pain-control decisions?. *Nursing*, 21(9), 44-48.
- McCaffery, M., & Ferrell, B. R. (1997). Nurses' knowledge of pain assessment and management: How much progress have we made? *Journal of Pain and Symptom Management*, 14(3), 175-188.
- McCaffery, M., Ferrell, B. R., & O'Neil-Page, E. (1992). Does life-style affect your pain-control decisions?. *Nursing*, 22(4), 58-61.

- McCarthy, B. (2006). Translating person-centred care: A case study of preceptor nurses and their teaching practices in acute care areas. *Journal of Clinical Nursing*, 15, 629-638.
- McDonald, D. D. (1994). Gender and ethnic stereotyping and narcotic analgesic administration. *Research in Nursing & Health*, 17(1), 45-49.
- McDonald, D. D., McNulty, J., Erickson, K., & Weiskopf, C. (2000). Communicating pain and pain management needs after surgery. *Applied Nursing Research*, 13(2), 70-75.
- McQuay, H. J., & Moore, R. A. (1998). *An Evidence-based Resource for Pain Relief*. London: Oxford University Press.
- Melia, K. M. (1982). "Tell it as it is"-Qualitative methodology and nursing research: Understanding the student nurse's world. *Journal of Advanced Nursing*, 7, 327-335.
- Merriam, S. B. (1988). *Case study research in education: A qualitative approach*. San Francisco, London: Jossey-Bass.
- Messeri, A., Abeti, M. S., Guidi, G., & Simonetti, M. (2008). Pain knowledge among doctors and nurses: A survey of 4912 healthcare providers in Tuscany. *Minerva Anestesiologica*, 74(4), 113-118.
- Michalowski, R. J. (1996). Ethnography and anxiety: Field work and reflexivity in the Vortex of U.S-Cuban relations. *Qualitative Sociology*, 19(1), 58-82.
- Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook* (2nd ed.). Thousand Oaks, London, New Delhi: Sage Publications, Inc.
- Miller, A. (2009). A sociological analysis of crimes of honor: Examining the effects of higher education on the concepts of honor and notions of gender equality in Jordan. [PhD Thesis]. Illinois Wesleyan University.
- Motl, R., Konopack, J., Hu, L., & McAuley, E. (2006). Does self-efficacy influence leg muscle pain during cycling exercise? *The Journal of Pain*, 7(5), 301-307.
- Muff, G. (1982). *Socialization, sexism, and stereotyping: Women's issues in nursing*. St Louis, MO: Mosby.
- Mulhall, A. (2003). In the field: Notes on observation in qualitative research. *Journal of Advanced Nursing*, 41(3), 306-313.
- Niekerk, L., & Martin, F. (2003). The impact of the nurse-physician relationship on barriers encountered by nurses during pain management. *Pain Management Nursing*, 4(1, March), 3-10.

Nieswiadomy, R. M. (1993). *Foundations of nursing research* (2nd ed.). East Norwalk, Connecticut: Appleton & Lange.

Orb, A., Eisenhauer, L., & Wynaden, D. (2000). Ethics in qualitative research. *Journal of Nursing Scholarship*, 33(1), 93-96.

Oweis, A. I. (2005). Bringing the professional challenges for nursing in Jordan to light. *Int J Nurs Pract*, 11(6), 244-249.

Oxford Dictionaries. (2010a). "Cronyism". 28-3-2011, from http://oxforddictionaries.com/view/entry/m_en_gb0192130#m_en_gb0192130

Oxford Dictionaries. (2010b). "Favouritism". 28-3-2011, from http://oxforddictionaries.com/view/entry/m_en_gb0289470#m_en_gb0289470

Oxford Dictionaries. (2010c). "Nepotism". 28-3-2011, from http://oxforddictionaries.com/view/entry/m_en_gb0553710#m_en_gb0553710

Oxford Dictionaries. (2010d). "Tribe". 23-3-2011, from http://oxforddictionaries.com/view/entry/m_en_gb0881090

Paice, J., Toy, C., & Shott, S. (1998). Barriers to cancer pain relief: Fear of tolerance and addiction. *Journal of Pain and Symptom Management*, 16(1), 1-9.

Papper, E. M., Brodie, B. B., & Rovenstine, E. A. (1952). Postoperative pain: Its use in the comparative evaluation of analgesics. *Surgery*, 32(1), 107-109.

Peter, E., Lunardi, V. L., & Macfarlane, A. (2004). Nursing resistance as ethical action: Literature review. *Journal of Advanced Nursing*, 46(4), 403-416.

Phillips, D. M. (2000). JCAHO pain management standards are unveiled. *JAMA*, 284(4), 428-429.

Plaisance, L., & Logan, C. (2006). Nursing students' knowledge and attitudes regarding pain. *Pain Management Nursing*, 7(4), 167-175.

Pletcher, M. J., Kertesz, S. G., Kohn, M. A., & Gonzales, R. (2008). Trends in opioid prescribing by race/ethnicity for patients seeking care in US emergency departments. *Jama-Journal of the American Medical Association*, 299(1), 70-78.

Pool, G., Schwegler, A., Theodore, B., & Fuchs, P. (2007). Role of gender norms and group identification on hypothetical and experimental pain tolerance. *Pain*, 129, 122-129.

Pope, C., van Royen, P., & Baker, R. (2002). Qualitative methods in research on healthcare quality. *Quality & Safety in Health Care*, 11(2), 148-152.

- Pope, C., Ziebland, S., & Mays, N. (2000a). Qualitative research in health care - Analysing qualitative data (Reprinted from Qualitative Research in Health Care). *British Medical Journal*, 320(7227), 114-116.
- Pope, C., Ziebland, S., & Mays, N. (2000b). Qualitative research in health care: Analysing qualitative data. *BMJ*, 320, 114–116.
- Pope, C., Ziebland, S., & Mays, N. (2006). Analyzing Qualitative Data. In C. Pope & N. Mays (Eds.), *Qualitative Search in Health Care* (3rd ed.): Blackwell Synergy.
- Potter, P., & Perry, A. (2001). *Fundamentals of nursing: Concept, process, and practice*. St Louis: Mosby.
- Price, K., & Cheek, J. (1996). Exploring the nursing role in pain management from a post-structuralist perspective. *Journal of Advanced Nursing*, 24(5), 899-904.
- Proshansky, H. M., Ittelson, W. H., & Rivlin, L. G. (Eds.). (1970). *Environmental psychology: Man and his physical setting*. London, New York: Holt, Rinehart, and Winston.
- Puntillo, K., & Weiss, S. J. (1994). Pain: Its mediators and associated morbidity in critically ill cardiovascular surgical patients. *Nursing Research*, 43, 31-36.
- Ragin, C. C. (1987). *The comparative method: Moving beyond the qualitative and quantitative strategies*. Berkeley, Los Angeles: University of California Press.
- Rahim-Williams, F., Riley III, J., Herrera, D., Campbell, C., Hastie, B., & Fillingim, R. (2007). Ethnic identity predicts experimental pain sensitivity in African American and Hispanics. *Pain*, 129(1-2), 177-184.
- Rahimi-Madiseh, M., Tavakol, M., & Dennick, R. (2010). A quantitative study of Iranian nursing students' knowledge and attitudes towards pain: Implication for education. *Int J Nurs Pract*, 16(5), 478-483.
- Reeves, S., Nelson, S., & Zwarenstein, M. (2008). The doctor-nurse game in the age of interprofessional care: A view from Canada. *Nursing Inquiry*, 15(1), 1-2.
- Rejeh, N., Ahmadi, F., Mohamadi, E., Anoosheh, M., & Kazemnejad, A. (2009). Ethical challenges in pain management post-surgery. *Nursing Ethics*, 16(2), 161-172.
- Rejeh, N., Ahmadi, F., Mohammadi, E., Anoosheh, M., & Kazemnejad, A. (2008). Barriers to, and facilitators of post-operative pain management in Iranian nursing: A qualitative research study. *International Nursing Review*, 55(4), 468-475.

- Rejeh, N., Ahmadi, F., Mohammadi, E., Kazemnejad, A., & Anoosheh, M. (2009). Nurses' experiences and perceptions of influencing barriers to postoperative pain management. *Scandinavian Journal of Caring Sciences*, 23(2), 274-281.
- Rich, B. (2000). An ethical analysis of the barriers to effective pain management. *Cambridge Quarterly of Healthcare Ethics*, 9, 54-70.
- Robins, P. (2004). *A history of Jordan*. Cambridge: Cambridge University Press.
- Rokke, P., Fleming-Ficek, S., Siemens, N., & Hegstad, H. (2004). Self-efficacy and choice of coping strategies for tolerating acute pain. *Journal of Behavioral Medicine*, 27(4).
- Rollman, G., Abdel-Shaheed, J., Gillespie, J., & Jones, K. (2004). Does past pain influence current pain: Biological and psychosocial models of sex differences. *European Journal of Pain*, 8, 427-433.
- Rothstein, W. G., & Hannum, S. (2007). Profession and gender in relationships between advanced practice nurses and physicians. *Journal of Professional Nursing*, 23(4), 235-240.
- Safdar, B., Heins, A., Homel, P., Miner, J., Neighbor, M., DeSandre, P., et al. (2009). Impact of Physician and Patient Gender on Pain Management in the Emergency Department-A Multicenter Study. *Pain Medicine*, 10(2), 364-372.
- Salibi, K. (2006). *The modern history of Jordan*. London, New York: I.B.Tauris & Co Ltd.
- Salvado-Hernandez, C., Fuentelsaz-Gallego, C., Arcay-Veira, C., Lopez-Melendez, C., Villar-Arnal, T., & Casas-Segala, N. (2009). Knowledge and attitudes on pain management by nurses in surgery and oncology in level III hospitals. *Enferm Clin*, 19(6), 322-329.
- Schafheutle, E. I., Cantrill, J. A., & Noyce, P. R. (2001). Why is pain management suboptimal on surgical wards? *Journal of Advanced Nursing*, 33(6), 728-737.
- Schlumberger, O. (2002). Transition to development? In G. Joffe (Ed.), *Jordan in transition 1990-2000* (pp. 225-253). London: Hurst and Co.
- Schrift, A. D. (1995). *Nietzsche's French legacy: A genealogy of poststructuralism*. New York, London: Routledge.
- Seale, C. (2004). *Researching society and culture* (2nd ed.). London: Sage Publications, Inc.
- Shoup, J. A. (2007). *Culture and customs of Jordan*. Westport, Connecticut, London: Greenwood Press.

Shugarman, L., Goebel, J., Lanto, A., Asch, S., Sherbourne, C., Lee, M., et al. (2010). Nursing staff, patient, and environmental factors associated with accurate pain assessment. *Journal of Pain and Symptom Management*, 40(5), 723-733.

Shuriquie, M., While, A., & Fitzpatrick, J. (2008). Nursing work in Jordan: An example of nursing work in the Middle East. *Journal of Clinical Nursing*, 17, 999-1010.

Sieber, J. E. (1992). *Planning Ethically Responsible Research: A guide for students and Internal Review Boards* (Vol. 31): Sage Publications Inc.

Sills, E. S., Genton, M. G., Walsh, A. P. H., & Wehbe, S. A. (2009). Who's asking? Patients may under-report postoperative pain scores to nurses (or over-report to surgeons) following surgery of the female reproductive tract. *Archives of Gynecology and Obstetrics*, 279(5), 771-774.

Simpson, J., & Carter, K. (2008). Muslim women's experiences with health care providers in a rural area of the United States. *Journal of Transcultural Nursing*, 19(1), 16-23.

Sinivaara, M., Suominen, T., Routasalo, P., & Hupli, M. (2004). How delivery ward staff exercise power over women in communication. *Journal of Advanced Nursing*, 46(1), 33-41.

Sjostrom, B., Haljamae, H., Dahlgren, L. O., & Lindstrom, B. (1997). Assessment of postoperative pain: Impact of clinical experience and professional role. *Acta Anaesthesiologica Scandinavica*, 41(3), 339-344.

Sloman, R., Rosen, G., Rom, M., & Shir, Y. (2005). Nurses' assessment of pain in surgical patients. *Journal of Advanced Nursing*, 52(2), 125-132.

Sommer, M., De Rijke, J. M., Van Kleef, M., Kessels, A. G., Peters, M. L., Geurts, J. W., et al. (2008). The prevalence of postoperative pain in a sample of 1490 surgical inpatients. *Eur J Anaesthesiol.*, 25(4), 267-274.

Sommer, M., Geurts, J., Stessel, B., Kessels, A. G. H., Peters, M. L., Patijn, J., et al. (2009). Prevalence and predictors of postoperative pain after ear, nose, and throat surgery. *Archives of Otolaryngology-Head & Neck Surgery*, 135(2), 124-130.

Stake, R. E. (1995). *The art of case study research*. Thousand Oaks, London, New Delhi: Sage Publications, Inc.

Starc, A. (2009). Nursing Professionalism in Slovenia: Knowledge, power, and ethics. *Nursing Science Quarterly*, 22(4), 371-374.

Stein, L. I. (1967). The doctor-nurse game. *Arch Gen Psychiatry*, 16(6), 699-703.

- Stein-Parbury, J., & Liaschenko, J. (2007). Understanding collaboration between nurses and physicians as knowledge at work. *American Journal of Critical Care*, 16(5), 470-477.
- Stomberg, M. W., Segerdahl, M., Rawal, N., Jakobsson, J., & Brattwall, M. (2008). Clinical practice and routines for day surgery in Sweden: Implications for improvement in nursing interventions. *J Perianesth Nurs*, 23(5), 311-320.
- Svensson, I., Sjostrom, B., & Haljamae, H. (2001). Influence of expectations and actual pain experiences on satisfaction with postoperative pain management. *European Journal of Pain*, 5, 125-133.
- Tanabe, P., Buschmann, M., Forest, R., & Forest, C. (2000). Emergency nurses' knowledge of pain management principles. *Journal of Emergency Nursing*, 26(4), 299-305.
- Tellis, W. (1997). Application of a case study methodology. *The Qualitative Report*, 3(3). 4-6-2009, from <http://www.nova.edu/ssss/QR/QR3-3/tellis2.html>
- Tellis-nayak, M., & Tellis-nayak, V. (1984). Games that professionals play: The social-psychology of physician-nurse interaction. *Social Science & Medicine*, 18(12), 1063-1069.
- Thomas, L. H. (1992). Qualified nurse and nursing auxiliary perceptions of their work environment in primary, team and functional nursing wards. *Journal of Advanced Nursing*, 17(3), 373-382.
- Thwaite, M. (2004). What is poststructuralism?. 16-5-2009, from <http://www.readysteadybook.com/Article.aspx?page=whatpoststructuralism>
- Tittle, M., & McMillan, S. C. (1994). Pain and pain-related side effects in an ICU and on a surgical unit: nurses' management. *Am J Crit Care*, 3(1), 25-30.
- Todd, K. H., Deaton, C., D'Adamo, A. P., & Goe, L. (2000). Ethnicity and analgesic practice. *Annals of Emergency Medicine*, 35(1), 11-16.
- Twycross, A. (2007). Children's nurses' post-operative pain management practices: An observational study. *International Journal of Nursing Studies*, 44(6), 869-881.
- Twycross, A. (2008). Does the perceived importance of a pain management task affect the quality of children's nurses' post-operative pain management practices? *Journal of Clinical Nursing*, 17(23), 3205-3216.
- Tzeng, J. I., Chou, L. F., & Lin, C. C. (2006). Concerns about reporting pain and using analgesics among Taiwanese postoperative patients. *Journal of Pain*, 7(11), 860-866.

Van Niekerk, L. M., & Martin, F. (2001). Tasmanian nurses' knowledge of pain management. *International Journal of Nursing Studies*, 38(2), 141-152.

Visentin, M., Trentin, L., De Marco, R., & Zanolin, E. (2001). Knowledge and attitudes of Italian medical staff towards the approach and treatment of patients in pain. *Journal of Pain and Symptom Management*, 22(5), 925-930.

Von Baeyer, C. L., Spagrud, L. J., McCormick, J. C., Choo, E., Neville, K., & Connelly, M. A. (2009). Three new datasets supporting use of the Numerical Rating Scale (NRS-11) for children's self-reports of pain intensity. *Pain*, 143(3), 223-227.

Waddington, D. (1994). Participant observation. In C. Cassell & G. Symon (Eds.), *Qualitative methods in organizational research: A practical guide* (1st ed., pp. 107-122). London: Sage Publications Ltd.

Wadensten, B., Frojd, C., Swenne, C., Gordh, T., & Gunningberg, L. (2011). Why is pain still not being assessed adequately? Results of a pain prevalence study in a University Hospital in Sweden. *Journal of Clinical Nursing*, 20(5-6), 624-634.

Ward, S. E., Goldberg, N., Miller-McCauley, V., Mueller, C., Nolan, A., Pawlik-Plank, D., et al. (1993). Patient-related barriers to management of cancer pain. *Pain*, 52(3), 319-324.

Watt-Watson, J., Chung, F., Chan, V. W. S., & McGillion, M. (2004). Pain management following discharge after ambulatory same-day surgery. *Journal of Nursing Management*, 12, 153-161.

Watt-Watson, J., Hunter, J., Pennefather, P., Librach, L., Raman-Wilms, L., Schreiber, M., et al. (2004). An integrated undergraduate pain curriculum, based on IASP curricula, for six Health Science Faculties. *Pain*, 110(1-2), 140-148.

Watt-Watson, J., Stevens, B., Garfinkel, P., Streiner, D., & Gallop, R. (2001). Relationship between nurses' pain knowledge and pain management outcomes for their postoperative cardiac patients. *Journal of Advanced Nursing*, 36(4), 535-545.

Watt-Watson, J. H. (1987). Nurses' knowledge of pain issues: A survey. *Journal of Pain and Symptom Management*, 2(4), 207-211.

Weedon, C. (1987). *Feminist practice & poststructuralist theory*. New York: Blackwell Publishers.

Weisse, C. S., Sorum, P. C., Sanders, K. N., & Syat, B. L. (2001). Do gender and race affect decisions about pain management? *Journal of General Internal Medicine*, 16(4), 211-217.

WHO. (2006). Mortality Country Fact Sheet 2006. 15-11-2008, from http://www.who.int/whosis/mort/profiles/mort_emro_jor_jordan.pdf

Wild, L. R., & Mitchell, P. H. (2000). Quality pain management outcomes: The power of place. *Outcomes Manag Nurs Pract*, 4(3), 136-143.

Wiles, R., Crow, G., Charles, V., & Heath, S. (2007). Informed consent and the research process: Following rules or striking balances? *Sociological Research Online*, 12(2).

Williams, A. C. D., Davies, H. T. O., & Chadury, Y. (2000). Simple pain rating scales hide complex idiosyncratic meanings. *Pain*, 85(3), 457-463.

Willson, H. (2000). Factors affecting the administration of analgesia to patients following repair of a fractured hip. *Journal of Advanced Nursing*, 31(5), 1145-1154.

Wilson, B. (2009). Can patient lifestyle influence the management of pain?. *Journal of Clinical Nursing*, 18(3), 399-408.

Winefield, H. R., Katsikitis, M., Hart, L. M., & Rounsefell, B. F. (1990). Postoperative pain experiences - Relevant patient and staff attitudes. *Journal of Psychosomatic Research*, 34(5), 543-552.

Wolfert, M. Z., Gilson, A. M., Dahl, J. L., & Cleary, J. F. (2010). Opioid Analgesics for Pain Control: Wisconsin physicians' knowledge, beliefs, attitudes, and prescribing practices. *Pain Medicine*, 11(3), 425-434.

Woods, N. F., & Catanzaro, M. (1988). *Nursing research: Theory and practice*. St Louis, MO: Mosby.

Wrong, D. H. (1979). *Power: Its forms, bases and uses*. Southampton, Great Britain: Basil Blackwell Publisher.

Wynd, C. A. (2003). Current factors contributing to professionalism in nursing. *Journal of Professional Nursing*, 19(5), 251-261.

Yates, P., Dewar, A., Edwards, H., Fentiman, B., Nash, R., Richardson, V., et al. (1998). The prevalence and perception of pain amongst hospital inpatients. *Journal of Clinical Nursing*, 7(6), 521-530.

Yin, R. (2003a). *Applications of case study research* (2nd ed.). California, London, New Delhi: Sage Publications, Inc.

Yin, R. (2003b). *Case study research: Design and Methods* (3rd ed.). California, London, New Delhi: Sage Publications, Inc.

Young, J. L., Horton, F. M., & Davidhizar, R. (2006). Nursing attitudes and beliefs in pain assessment and management. *Journal of Advanced Nursing*, 53(4), 412-421.

Zakari, N. M., Al Khamis, N. I., & Hamadi, H. Y. (2010). Conflict and professionalism: Perceptions among nurses in Saudi Arabia. *International Nursing Review*, 57(3), 297-304.

Zanolin, M. E., Visentin, M., Trentin, L., Saiani, L., Brugnolli, A., & Grassi, M. (2007). A questionnaire to evaluate the knowledge and attitudes of health care providers on pain. *Journal of Pain and Symptom Management*, 33(6), 727-736.

Zeilani, R., & Seymour, J. E. (2010). Muslim women's experiences of suffering in Jordanian intensive care units: A narrative study. *Intensive Crit Care Nurs*, 26(3), 175-184.

Zelek, B., & Phillips, S. (2003). Gender and power: Nurses and doctors in Canada. *International Journal for Equity in Health*, 2(1).

Appendices

Appendix One

Key searching terms used to review literature

Topic	Searching terms	Searched Database
Pain prevalence	1. Pain & prevalence 2. Postoperative pain & prevalence	Medline (Map term, Tree) Google scholar (Free text)
	Postoperative pain & prevalence	PubMed (MeSH)
	Postoperative (topic) & pain (topic) & prevalence (topic)	Web of Knowledge (Free text)
	Postoperative & pain & prevalence (in text)	CINAHL EBSCO (Free text, advanced search)
	Postoperative OR post-operative (abstract) & pain (abstract) & prevalence OR intensity (abstract)	ASSIA (Free text)
professional-patient relationship	1. Nurse OR nursing & relation OR relationship & pain 2. Nurse OR nursing & pain & therapeutic 3. Nurse OR nursing & communication & pain 4. Nurse OR nursing & empathy OR rapport	ASSIA and Google scholar (Free text)
	Nurse-patient relations	PubMed (MeSH) CINAHL Ovid (MeSH)
	Doctor-patient relations	PubMed (MeSH)
Nurse-doctor relationship	Physician-nurse relations	PubMed (MeSH)
	Interprofessional relations	CINAHL Ovid & PubMed (MeSH)
	Nurse & Physician & relation	ASSIA (Free text)
	Nurse & [Doctor OR physician] & gender	Web of knowledge (Free text)
	Nurse & [doctor OR physician] & power	JSTOR, Google scholar (Free text)
	Nurse & [doctor OR physician] & socioeconomic	Google scholar (Free Text)
	Nurse & [doctor OR physician] & knowledge	Google scholar (Free text)
Power	Surveillance & Nursing OR nurse Surveillance & pain Surveillance & hospitals	Google Scholar & Web of Knowledge (Free text)
	Gaze & Hospital Gaze & pain Gaze & nursing OR nurse	Google Scholar & Web of Knowledge (Free text)
	Knowledge (title) & pain (title)	Web of Knowledge (Free text)

	Nurse & pain & knowledge	PubMed (MeSH), PubMed(free text)
	1. exp Pain/ 2. exp Attitude/ 3. exp Health Knowledge, Attitudes, Practice/ 4. 1 and 3 5. limit 4 to (English language and humans)	Medline Ovid (Tree, Map term)
Nurses assessment of pain	1. exp Pain/ 2. exp Nursing Assessment/ 3. 1 and 2 4. limit 3 to (English language and humans)	Medline Ovid (Tree, map term)
Barriers to pain management	"Pain & Barriers" (in title)	Web of knowledge (Free text)
Research in Jordan about pain	Pain & Jordan	PubMed MeSH
	Pain (Title) & Jordan (Topic)	Web of Knowledge & Google scholar (Free text)
Foucault and nursing	Foucault & Nursing	Google scholar (Free text)
	Poststructural & nursing/ Post-structural & nursing Nursing & Discourse Discourse & space & nursing & hospital	Google scholar (Free text)
Study Organization poststructurally	Organization & discourse	Google scholar (Free text)
	Organization & [poststructural OR post-structural]	Google scholar (Free text)
	Environmental psychology & space	Google Scholar (Free text)
Military context and pain	"Military & pain" in 'Title', in 'text'	Google scholar (Free text)
Patient centred care	Patient AND partnership OR collaboration OR centred care OR empower OR participation OR involvement	Google scholar (Free text)
References of the retrieved studies were also reviewed.		

Appendix Two (A)

Letter from the Dean of Nursing School where the researcher worked, to the Dean of Nursing School in the governmental university

UNIVERSITY Faculty of Nursing Dean's Office	جامعة كلية التمريض مكتب العميد
--	---

التاريخ: 2009/3/31
الرقم: ٣٦٠/22/100

حضرة الدكتورة عميدة كلية التمريض المحترم،
جامعة

أرجو اجراء ما ترونه مناسباً بشأن تسهيل مهمة الباحثة ميادة عوض دعيبس لإجراء البحث العلمي المتعلق بـ "العوامل المؤثرة على عملية ادارة الالم بعد العمليات عند مرضى الجراحة البالغين" لغاية استكمال درجة الدكتوراة في التمريض من جامعة ووريك/بريطانيا حيث سنقوم بجمع المعلومات اللازمة لاستكمال البحث عن طريق مقابلة بعض اعضاء الهيئة التدريسية ممن لهم تجربة في تدريس ادارة الالم و مقابلة بعض الطلبة و مراجعة خطط المساق ذات العلاقة

يرجى الكرم بتسهيل مهمتها علما بان تفاصيل جمع المعلومات و منهجيه درسه مذكورة بالتفصيل في مشروع البحث المرفق طيا.

وتفضلوا بقبول فائق الاحترام،

ق. ا. عميد كلية التمريض
د.

الجامعة هاتف (٩٦٢) فرعي (٩٦٢) فاكس (٩٦٢) ص.ب. الأردن - البريد الالكتروني: nursing@edu.jo
Tel. (962) - Fax. (962) - P.O.Box: Jordan - E-mail: nursing@edu.jo

Appendix Two (A.1)

Letter from the Dean of Nursing School in the Governmental University
to the Head of IRB in the same University

جامعة كلية التمريض	Faculty of Nursing
ص.ب. (962-2) الأردن فاكس (962-2)	هاتف
الرقم: ١٠٤٨/١٤/١٥/٥	Ref. :
التاريخ: ٥/٤/١٥ م	Date :
الموافق: ٥/٤/١٥ م	
الأستاذ الدكتور رئيس لجنة البحث على الإنسان كلية الطب	
تحية طيبة وبعد ،،،	
أرجو التكرم بالموافقة وعرض موضوع بحث طالبة الدكتوراه ميادة عوض دعيبس على لجنة البحث على الإنسان وموضوعه:	
"العوامل المؤثرة على عملية علاج الألم بعد العمليات عند مرضى الجراحة البالغين"	
والذي تقوم به لاستكمال متطلبات الحصول على درجة الدكتوراه من جامعة ووريك/بريطانيا وستقوم بمقابلة أعضاء هيئة التدريس ذوي العلاقة بتدريس إدارة وعلاج الألم وكذلك مقابلة بعض الطلبة.	
وتفضلوا بقبول فائق الاحترام،،،	
ق.أ. عميد كلية التمريض الدكتور	
صلى الله عليه وسلم	
15.04.2009	
الرقم: ١٠٤٨/١٤/١٥/٥	
P.O. Box: Jordan E-mail: nursing@.....edu.jo	
Tel.: (962-2) - Ext: 23606 Fax: (962-2)	

Letter from the Head of the IRB in the Governmental University granting ethical and access permission

343

Letter from the Dean of Nursing School in the Private University to the Head of the IRB in the Private University

344

Appendix Two (B.1)

Letter from the Dean of the Nursing School in the Private University confirming the ethical and access permission granted from the Head of the IRB in the same University

UNIVERSITY Faculty of Nursing Dean's Office	جامعة كلية التمريض مكتب العميد
التاريخ: 2009/4/6 الرقم: ٢٢٢/22/100	
حضرة السيدة ميادة دعيبس المحترمة جامعة	
<p>أرجو اعلامكم بأن مجلس البحث العلمي والدراسات العليا في جلسته المنعقدة بتاريخ 2009/4/1 قد وافق على إجراء البحث العلمي المتعلق بـ "العوامل المؤثرة على عملية إدارة الألم بعد العمليات عند مرضى الجراحة البالغين" ويمكنك البدء في جمع البيانات اللازمة حسب الجدول الزمني المتفق عليه في مشروع البحث.</p> <p>أتمنى لك التوفيق والنجاح،،</p> <p>وتفضلوا بقبول فائق الاحترام،،</p> <p>ق.أ. عميد كلية التمريض</p>	
<p>الجامعة هاتف (٩٦٢) فرعي : ، فاكس (٩٦٢) ، ص.ب. : ، الأردن - البريد الإلكتروني : nursing@ .edu.jo Tel. (962) - Fax. (962) - P.O.Box : Jordan - E-mail:nursing@ .edu.jo</p>	

Appendix Two (C)

Letter from the Dean of the Nursing School in the Private University, where the researcher is an employer, to the Minister of Health asking for ethical and access permission to the Public Hospital

UNIVERSITY Faculty of Nursing Dean's Office	جامعة كلية التمريض مكتب العميد
--	---

التاريخ: 2009/3/31
الرقم: ٢٠٠٩/٢٠/١٠٠

معالي الدكتور وزير الصحة الأكرم،،

تحية طيبة وبعد،،

أرجو اجراء ما ترونه مناسباً بشأن تسهيل مهمة الباحثة ميادة عوض دعبس لإجراء البحث العلمي المتعلق بـ "العوامل المؤثرة على عملية ادارة الألم بعد العمليات عند مرضى الجراحة البالغين" لغاية استكمال درجة الدكتوراة في التمريض من جامعة ووريك/بريطانيا حيث ستقوم بجمع المعلومات عن طريق مقابلة بعض المرضى وذويهم وبعض افراد الطاقم التمريضي والطبي، و مراقبة العملية التمريضية لإدارة الألم، ومراجعة بعض ملفات المرضى لذات الغاية. يرجى التكرم بتسهيل مهمتها، علماً بأن تفاصيل جمع المعلومات و منهجية الدراسة المذكورة بالتفصيل في مشروع البحث المرفق طياً.

وتفضلوا بقبول فائق الاحترام،،

ق. ا. عميد كلية التمريض

١ نيسان ٢٠٠٩

Code: [Redacted]

الجامعة هاتف: (٩٦٢) [Redacted] فاكس: (٩٦٢) [Redacted] ص.ب. [Redacted] الأردن - البريد الالكتروني: nursing@ [Redacted] .edu.jo
Tel. (962) [Redacted] Ext. [Redacted] - Fax. (962) [Redacted] - P.O.Box [Redacted] Jordan - E-mail: nursing@ [Redacted] .edu.jo

Letter from the Ministry of Health forwarded to the manager of the Public hospital confirming granting to the researcher the requested ethical and access permission to the Public Hospital

347

Letter from the manager of the Public Hospital to the researcher confirming granting the ethical and access permission upon the agreement of the internal committee of ethics and the Ministry of Health

348

Appendix Two (D)

Letter from the Dean of Nursing School, where the researcher is an employer, to the Higher Command of the Royal Medical Services, Jordan, requesting ethical and access permission to the Military Hospital

UNIVERSITY
Faculty of Nursing
Dean's Office

جامعة
كلية التمريض
مكتب العميد

التاريخ: 2009/3/31
الرقم: 663/20/100

عطفة الدكتور مدير الخدمات الطبية الملكية المحترم،،

تحية طيبة وبعد،،

أرجو إجراء ما ترونه مناسباً بشأن تسهيل مهمة الباحثة ميدانة عوض دعيس لإجراء البحث العلمي المتعلق بـ "العوامل المؤثرة على عملية إدارة الألم بعد العمليات عند مرضى الجراحة الباطنية" لغاية استكمال درجة الدكتوراة في التمريض من جامعة ووريك/بريطانيا حيث ستقوم بجمع المعلومات عن طريق مقابلة بعض المرضى وذويهم وبعض أفراد الطاقم التمريضي والطبي، و مراقبة العملية التمريضية لإدارة الألم، ومراجعة بعض ملفات المرضى لذات الغاية يرجى التكرم بتسهيل مهمتها، علماً بأن تفاصيل جمع المعلومات و منهجية الدراسة المذكورة بالتفصيل في مشروع البحث المرفق طياً.

وتفضلوا بقبول فائق الاحترام،،

د. أ. عميد كلية التمريض

الجامعة مالكو
البريد الإلكتروني: nursing@...
Tel. (962) ... Ext. (2153) • Fax. (962) ... P.O. Box ...
... Jordan • E-mail: nursing@...

Appendix Two (D.1)

Letter from the Higher Command of the Royal Medical Services, Jordan, confirming granting ethical and access permission to the Military Hospital

بسم الله الرحمن الرحيم

G. H. Q. Jordan Armed Forces
DIRECTORATE
ROYAL MEDICAL SERVICES
Director of Professional Training
and Human Resources Development
Amman - Jordan

القيادة العامة للقوات المسلحة الأردنية
مديرية
الخدمات الطبية الملكية
مديرية التأهيل الفني وتنمية القوى البشرية
عمان - الأردن

الرقم: ت ف ١/٤/١
التاريخ: رمضان ١٤٣٠
٢٠٠٩ آب ٥

الموضوع: الدراسات

تحية طيبة وبعد

١. تمت الموافقة على السماح للباحثة مياده عوض دعيبس من جامعة [REDACTED] بإجراء علمي حول ((العوامل المؤثرة على عملية إدارة الألم بعد العمليات عند مرضى الجراحة الباليغين)) بعد التنسيق مع العقيد الطبيب مصطفى بينو / عيادة الألم وحسب قرار لجنة البحوث والدراسات الدوائية والسريرية وأخلاقيات المهنة بتاريخ ٢٠٠٩/٥/٤ .

٢. لإجراء انكم لطفاً .

ع/ اللواء الطبيب
مدير عام الخدمات الطبية الملكية
[Signature]

الى :

- المساعد للشؤون الطبية
- مدير التأهيل الفني وتنمية القوى البشرية
- رئيس شعبة امن الخدمات الطبية ، اشارة للتصريح الامني رقم (٧٨٣)
- سكرتيرة لجنة اخلاقيات المهنة
- التداول

بمكتبه
٢٠٠٩/٨/١٠

FAX: 962-6-5347485 TEL: 5804804 EXT: 4341/4373 P.O. BOX: 122 Dahyat Al-Amir Rashid, Amman 11831 Jordan
فاكس: ٩٦٢-٦-٥٣٤٧٤٨٥ ، تلفون: ٥٨٠٤٨٠٤ فرعي ٤٣٤٢/٤٣٤١/٤٣٧٣ ص.ب ١٢٢ ضاحية الأمير راشد، عمان ١١٨٣١ الأردن

SGS UKAS

Appendix Three (A)

Information letter and consent form (Patients- Arabic Version)

نموذج الموافقة على الاشتراك في دراسة

" ما هي العوامل المؤثرة على عملية ادارة الألم بعد العمليات عند مرضى الجراحة البالغين في
المستشفيات الاردنية؟"
جامعة ووريك
(مرضى الجراحة)

سوف تقوم الباحثة بدراسة العوامل التي قد تؤثر على عملية إدارة الألم بعد العمليات عند مرضى الجراحة البالغين في المستشفيات الأردنية.
أنت/ أنتي مدعوة للمشاركة في هذه الدراسة. تمت دعوتك لتكون من ضمن المشاركين في هذه الدراسة لأنك
تبلغ من العمر أكثر من 18 عاماً، خضعت أو سوف تخضع لعملية جراحية أثناء فترة دخولك للمشفى ،
ومشاركتك قد تغني نتائج هذه الدراسة .

الرجاء قراءة المعلومات المذكورة لاحقاً. بإمكانك طرح أي استفسار عن أي شيء متعلق بالدراسة قبل الموافقة
على الاشتراك الطوعي في هذه الدراسة.

من سيقوم بإجراء الدراسة:

اسم الباحث: ميادة دعبس.
المشرفتين على الدراسة: د. كيت سيرز
د. لورين بلاكستر
اسم الكلية/الجامعة: كلية الأبحاث الصحية و الاجتماعية/ جامعة ووريك/ المملكة المتحدة

هدف الدراسة:

هدف هذه الدراسة هو دراسة العوامل التي قد تؤثر على عملية إدارة الألم بعد العمليات عند مرضى الجراحة البالغين في المستشفيات الأردنية.

طريقة عمل البحث:

بناء على موافقتك الطوعية على الاشتراك في هذه الدراسة، سوف تكون أحد/ى المرضى الذين تتم مراقبة
الاجراءات و المداخلات الطبية و التمريضية التي تجرى لهم بعد العملية بالإضافة الى مراقبة اتصالاتك بالطواقم
التمريضية و الطبي. بالإضافة الى ذلك سوف تقوم الباحثة بالاطلاع على ملفك الطبي لأخذ بعض المعلومات
المتعلقة بعمليتك الجراحية. بعد ذلك سوف اقوم بالترتيب معك لعمل مقابلة كلامية للتحديث عن وضعك الصحي
العام بعد العملية. قد تستمر هذه المقابلة لمدة تصل الى الساعة. اذا احسست بأنك متعب أثناء المقابلة، سوف
اعود لاحقاً و أكمل معك المقابلة التي كنا قد بدأناها. بناء على موافقتك المسبقة، سوف يتم تسجيل المقابلة
صوتياً حتى تتمكن الباحثة من الانتباه لكل ما تقوله و تجنب فقدان أي معلومة قد تقولها. في حال رفضك
لتسجيل المقابلة، سوف تقوم الباحثة بتدوين المقابلة خطياً على الورق.

مخاطر و فوائد الاشتراك في هذه الدراسة:

هذه الدراسة لا تتطلب على أي مخاطر جسدية او مداخلات دوائية او طبية من أي نوع ولكن في حال شعرت
ان الحديث عن حالتك بعد العملية يشكل ضرراً نفسياً لك، لك ان تنسحب من الدراسة في أي وقت تشاء.
ان انخراطك في هذه الدراسة يشكل فائدة لنجاح هذا البحث الذي يحمل بعد تحليل نتائجه فوائد لتطوير المعرفة
عن حالة المرضى بعد العمليات في المستشفيات الأردنية.

السرية:

جميع الأوراق و المعلومات المتعلقة بهذه الدراسة سوف تحفظ بطريقة تضمن سرية ما تنطوي عليه. أي نوع من النتائج التي سيتم نشرها بعد تحليل المعلومات لن تتضمن ما يشير أو يدل على صاحب أو مصدر هذه المعلومات.

فقط الأحرف الأولى من اسمك سوف تدون أثناء إجراء المقابلة أو كتابة أي ملحوظة متعلقة بك. جميع المعلومات مثل حالتك الصحية، معلومات تم أخذها من ملفك المرضي ذات العلاقة بطبيعة العملية التي أجريت لك، وتسجيل المقابلة الصوتي سوف تحفظ في ملفات الكترونية ذات أرقام سرية لا يعرفها إلا الباحث. هذه الملفات سوف تخزن على اقراص مدمجة و تشطب عن جهاز الحاسب الخاص بالباحث لأغراض الحفاظ على سريتها.

سوف يتم الاحتفاظ بهذه المعلومات لمدة ست سنوات من تاريخ موافقتك على الاشتراك بهذه الدراسة ثم سوف تتلف بالطريقة المناسبة.

يعتبر الاشتراك في هذه الدراسة إراديا بحثا:

يجب أن تكون مشاركتك في هذه الدراسة مشاركة طوعية بالكامل. قرارك، سواء بالموافقة على المشاركة في الدراسة أو الرفض، سوف لن يؤثر على علاقتك الحالية أو المستقبلية مع الأطباء، أفراد الطاقم التمريضي، أو أي جهة أخرى داخل أو خارج المستشفى، أو على علاقتك بجامعة ووريك. بالإضافة إلى ذلك، إن قرارك سواء بالموافقة أو الرفض سوف لن يؤثر على شكل و نوعية العناية المقدمة لك.

إذا وافقت على الاشتراك في هذه الدراسة فإنك تستطيع لاحقا الانسحاب من الدراسة أثناء المراقبة، و قبل أو أثناء المقابلة بدون أن يؤثر ذلك على العناية المقدمة لك. في حال قررت الانسحاب من الدراسة بعد أن تكون قد بدأت، سوف لن يتم استخدام أي معلومة جمعت منك قبل قرار الانسحاب و سوف يتم إتلافها فوراً بالطريقة المناسبة.

للاتصال و الاستفسار:

اسم الباحثة: ميادة دعبيس

إذا كان لديك أي استفسار، الرجاء طرحه الآن. إذا تولد لديك أي سؤال أو استفسار لاحقاً، يرجى الاتصال بي شخصياً أثناء تواجدتي بالمشفى أو الاتصال بي على رقم الهاتف: 00962-777-994854

المشرفين على الدراسة هم:

د. كيت سيرز

عضو هيئة البحث التمريضي/ الكلية الملكية البريطانية للتمريض
رئيس مركز البحوث التمريضية/ كلية الدراسات الصحية و الاجتماعية
جامعة ووريك

هاتف: 0044-24-7615

فاكس: 0044-24-76150643

د. لورين بلاكستر

كلية الدراسات الصحية و الاجتماعية
جامعة ووريك

هاتف: 0044-24-76574098

فاكس: 0044-24-76524415

أو بإمكانك الاتصال بجامعة ووريك على العنوان التالي:

School of Health and Social Studies
University of Warwick
www.warwick.ac.uk
CV4 7AL
Coventry
United Kingdom

سوف يتم تزويك بنسخة من هذا النموذج. الرجاء الاحتفاظ به.

نموذج الموافقة على الاشتراك
في دراسة

" ما هي العوامل المؤثرة على عملية ادارة الألم بعد العمليات عند مرضى الجراحة البالغين في
المستشفيات الاردنية؟"

بنود المشاركة بالدراسة:

الرجاء وضع اشارة (√) بجانب كل بند توافق عليه:

<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>

- قرأت المعلومات الواردة في هذا الاتفاق و فهمتها فهما كاملا.
- جميع استفساراتي تم الاجابة عليها بوضوح.
- أشهد انني ابلغ من العمر اكثر من 18 عاما.
- أمنح موافقتي على تسجيل المقابلة تسجيلا صوتيا.
- أمنح موافقتي للباحثة للاطلاع على ملفي الطبي.
- أنا أوافق على المشاركة في هذه الدراسة.

..... التاريخ

..... توقيع المشارك

..... اسم المشارك

..... التاريخ

..... توقيع الباحثة

سوف يتم تزويدك بنسخة من هذا النموذج. الرجاء الاحتفاظ به.
نسخة المشارك

نموذج الموافقة على الاشتراك

في دراسة

" ما هي العوامل المؤثرة على عملية ادارة الالم بعد العمليات عند مرضى الجراحة البالغين في
المستشفيات الاردنية؟"

بنود المشاركة بالدراسة:

الرجاء وضع اشارة (√) بجانب كل بند توافق عليه:

☐
☐
☐
☐
☐
☐

- قرأت المعلومات الواردة في هذا الاتفاق و فهمتها فهما كاملا.
- جميع استفساراتي تم الاجابة عليها بوضوح.
- أشهد انني ابلغ من العمر اكثر من 18 عاما.
- أمنح موافقتي على تسجيل المقابلة تسجيلا صوتيا.
- أمنح موافقتي للباحثة للاطلاع على ملفي الطبي.
- أنا أوافق على المشاركة في هذه الدراسة.

..... التاريخ

..... توقيع المشارك

..... اسم المشارك

..... التاريخ

..... توقيع الباحثة

Appendix Three (A.1)

Information letter and consent form (Patients- English Version)

CONSENT FORM
(PATIENT)
THE UNIVERSITY OF WARWICK

What issues influence postoperative pain management in Jordanian hospitals?

I am conducting a study about *issues that might influence postoperative pain management among adult patients in surgical wards in Jordanian hospitals*. I invite you to participate in this research. You were selected as a possible participant because you are an adult surgical client who have/or will have a surgery and might help giving some data about your general condition postoperatively. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by:

Name of researcher: Mayada Daibes,
Name of advisor: Prof. Kate Seers & Dr. Loraine Blaxter
Department: School of health and Social Studies, The University of Warwick, United Kingdom.

Background Information:

The purpose of this study is to identify potential factors influencing postoperative pain management among adult patients in Jordanian hospitals.

Procedures:

If you agree to be in this study, an interview with you to talk about your general postoperative general condition and pain will be arranged. This interview might last up to one hour. If you felt tired, I would come back another time and see whether you would like to continue the interview. If you agreed, interviews will be recorded using audio-digital recorder to help keep attention to what you say. If you do not agree to record the interview, I will write down notes on interview papers.

Risks and Benefits of Being in the Study:

This study has no physical risks. However, if you found that talking about your postoperative general condition might threat you in any way, you can withdraw at any time.

Confidentiality:

The records of this study will be kept confidential. In any sort of report I publish, I will not include information that will make it possible to identify you in any way. Only initials of your name will asked from you during the interview or data collection. Other data related to you such as health condition, full

Page -1-

interviews records, and Audio recorded interviews will be stored in encrypted secured files whether as a software or hardware for six years and then will be damaged as appropriate.

Voluntary Nature of the Study:

Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with doctors, nurses, or any other part in the hospital or the University of Warwick. In addition, your decision whether to or not to participate will not affect your care. If you decide to participate, you are free to withdraw at any time before or during observation or interview without affecting your care. Should you decide to withdraw; data collected about you will not be used for the purpose of the research and will be damaged immediately as appropriate.

Contacts and Questions

My name is *Mayada Daibes*. You may ask any questions you have now. If you have questions later, you may contact me in person while be in the hospital or at 00962-777-994854

My advisors' names are:

1. Professor Kate Seers
Director, RCN Research Institute
School of Health and Social Studies
The University of Warwick
Coventry, CV4 7AL
Tel: 024 7615 0614
Fax: 024 7615 0643
2. Dr. Loraine Blaxter
Institute of Health,
School of Health and Social Studies,
The University of Warwick,
Coventry, CV4 7AL

Tel: +44 (0)24 7657 4098
Fax: +44 (0)24 7652 4415

You may also contact:
School of Health and Social Studies
University of Warwick
www.warwick.ac.uk
CV4 7AL
United Kingdom

You will be given a copy of this form to keep for your records.

Statement of Consent

Please tick beside the sentence to which you grant your consent:

- | | |
|--|--------------------------|
| I have read the above information and fully understood it. | <input type="checkbox"/> |
| My questions have been answered to my satisfaction. | <input type="checkbox"/> |
| I am at least 18 years of age. | <input type="checkbox"/> |
| I grant my permission to the researcher to look at my medical record for the purpose of the research only. | <input type="checkbox"/> |
| I grant my permission to record the interview by audio-digital recorder. | <input type="checkbox"/> |
| I consent to participate in the study. | <input type="checkbox"/> |

Signature of study Participant

Date

Print Name of Study Participant

Signature of Researcher

Date

Participant's copy

Statement of Consent

Please tick beside the sentence to which you grant your consent:

I have read the above information and fully understood it.

☐

My questions have been answered to my satisfaction.

☐

I am at least 18 years of age.

☐

I grant my permission to the researcher to look at my medical record for the purpose of the research only.

☐

I grant my permission to record the interview by audio-digital recorder.

☐

I consent to participate in the study.

☐

Signature of study Participant

Date

Print Name of Study Participant

Signature of Researcher

Date

Appendix Three (A.1.1)

Informed consent form nominated by the JMoH to be used for research purposes when inviting patients to participate in research

<p>..... اسم المريض: رقم الملف : الرقم الوطني: الطبيب المعالج:</p>	<p>المملكة الأردنية الهاشمية وزارة الصحة</p>
<p>نموذج الموافقة المبينة على المعرفة تفويض من المريض المتطوع بإجراء البحث عليه</p>	
<p>اليوم: التاريخ: الساعة:</p>	
<p>1. بهذا ألتطوع في هذا البحث تحت إشراف..... أو أحد المشاركين معه بمستشفى..... والمتضمن لما يلي:</p> <p>2. أقر بأنني قد قرأت - أو شرح لي بلغة مفهومة لدي - هذه المعلومات المتعلقة بتطوعي في هذا البحث وأن الدكتور / السيد قد أوضح لي طبيعة وأهداف هذه الدراسة، كما أقر بأنه قد أتحت لي الفرصة لتوجيه جميع الأسئلة المتعلقة بموضوع الدراسة وتلقيت الإجابات الشافية.</p> <p>3. أفهم بأن هذه الدراسة ليس لها أي فائدة علاجية مباشرة لي ومع ذلك ألتطوع فيها مع علمي بالمخاطر الناتجة عنها.</p> <p>4. وأفهم بأن لي مطلق الحرية بسحب هذا التفويض وإنهاء تطوعي بهذه الدراسة في أي وقت أرغب مع علمي بجميع العواقب والمخاطر المترتبة على انسحابي من الدراسة (إن وجدت). كما أفهم بأن انسحابي من هذه للدراسة لن يؤثر على حقّي في تلقي العناية الطبية اللازمة والتي تمنح للمتطوعين بالدراسة أو استحقاقها في الأحوال العادية.</p> <p>5. كما أؤكد بأنني قد قرأت (أو قرأ لي) هذا التفويض وأن كل المعلومات اللازمة قد تمت تعييتها بدقة قبل توقيع عليّ.</p> <p>اسم المريض/أو من ينوب عنه :</p> <p>توقيع المريض/أو من ينوب عنه :</p> <p>شاهد :</p> <p>التوقيع:</p>	
<p>أقر بأنني قد شرحت للمتطوع/ /أو من ينوب عنه والمذكور أعلاه بصورة كاملة طبيعة وأهداف مشروع البحث المذكور والمتضمن عدم وجود فائدة مباشرة له . كما قد شرحت له المضاعفات المحتملة حدوثها من جراء هذه الدراسة سواء كانت لأسباب معروفة أو غير معروفة. كما إنه من المفهوم لدي بأنه قد فهم طبيعة الدراسة والغرض منها والمخاطر الناتجة عنها وذلك قبل توقيع عليه على الموافقة بالتطوع، ولقد قمت بتوضيح استعدادي للإجابة على أي أسئلة متصلة بهذه الدراسة، وقمت فعلاً بالإجابة الشافية على جميع أسئلته المتعلقة بالدراسة.</p> <p>اسم الباحث الرئيسي: التوقيع:</p>	

Appendix Three (B)

Information letter and consent form (Staff Nurses- Arabic Version)

نموذج الموافقة على الاشتراك في دراسة

" ما هي العوامل المؤثرة على عملية ادارة الالم بعد العمليات عند مرضى الجراحة البالغين في
المستشفيات الاردنية؟"
جامعة ووريك
(ممرض/ة قانوني/ة)

سوف تقوم الباحثة بدراسة العوامل التي قد تؤثر على عملية إدارة الألم بعد العمليات عند مرضى الجراحة البالغين في المستشفيات الأردنية. أنت/ أنتي مدعوة للمشاركة في هذه الدراسة لانك تبلغ من العمر أكثر من 18 عاماً، حاصل على درجة تعادل البكالوريوس في التمريض من إحدى الجامعات الأردنية ، تعمل في قسم الجراحة و مع مرضى الجراحة البالغين، بالإضافة الى أن مشاركتك و أرائك عن إدارة الألم بعد العمليات عند مرضى الجراحة قد تغني نتائج هذه الدراسة .

الرجاء قراءة المعلومات المذكورة لاحقاً. بإمكانك طرح أي استفسار عن أي شيء متعلق بالدراسة قبل الموافقة على الاشتراك الطوعي في هذه الدراسة.

من سيقوم بإجراء الدراسة:

اسم الباحث: ميادة دعبس.
المشرفين على الدراسة: د. كيت سيرز
د. لورين بلاكستر
اسم الكلية/الجامعة: كلية الأبحاث الصحية و الاجتماعية/ جامعة ووريك/ المملكة المتحدة

هدف الدراسة:

هدف هذه الدراسة هو دراسة العوامل التي قد تؤثر على عملية ادارة الالم بعد العمليات عند مرضى الجراحة البالغين في المستشفيات الاردنية.

طريقة عمل البحث:

بناء على موافقتك الطوعية على الاشتراك في هذه الدراسة، سوف تكون إحدى أفراد الطاقم التمريضي الذين تتم مراقبة المداخلات التمريضية التي يقومون بها لمرضى الجراحة بالإضافة الى مراقبة اتصالك بأفراد الطاقم التمريضي الآخرين و علاقتك بالمرضى بالإضافة الى طرح بعض الاسئلة للاستيضاح اثناء المراقبة. بعد ذلك سوف اقوم بالترتيب معك لعمل مقابلة كلامية للتحدث عن العوامل التي قد تساعد على نجاح او فشل عملية إدارة الألم في أقسام الجراحة من واقع تجربتك العملية. قد تستمر هذه المقابلة لمدة تصل الى الساعة. بناء على موافقتك المسبقة، سوف يتم تسجيل المقابلة صوتياً حتى تتمكن الباحثة من الانتباه لكل ما تقوله و تجنب فقدان أي معلومة قد تقولها. في حال رفضك لتسجيل المقابلة، سوف تقوم الباحثة بتدوين المقابلة خطياً على الورق.

فوائد و مخاطر الاشتراك في هذه الدراسة:

هذه الدراسة لا تنطوي على أي مخاطر جسمية او مداخلات دوائية او طبية. ولكن في حال شعرت بأي نوع من عدم الارتياح، لك كامل الحق بالانسحاب الموقت و الدائم من الدراسة.
ان انخراطك في هذه الدراسة يشكل فائدة لنجاح هذا البحث الذي يحمل بعد تحليل نتائجه فوائد لتطوير المعرفة عن حالة الألم و كيفية إدارة الألم عند مرضى الجراحة بعد العمليات في المستشفيات الاردنية.

السرية:

جميع الأوراق والمعلومات المتعلقة بهذه الدراسة سوف تحفظ بطريقة تضمن سرية ما تنطوي عليه. أي نوع من النتائج التي سيتم نشرها بعد تحليل المعلومات لن تتضمن ما يشير أو يدل على صاحب أو مصدر هذه المعلومات.

فقط الأحرف الأولى من اسمك سوف تدون أثناء اجراء المقابلة أو كتابة أي ملحوظة متعلقة بك. جميع المعلومات (مثل عدد سنوات الخبرة، تسجيل المقابلة الصوتي) سوف تحفظ في ملفات الكترونية ذات ارقام سرية لا يعرفها الا الباحث. هذه الملفات سوف تخزن على اقراص مدمجة و تشطب عن جهاز الحاسب الخاص بالباحث لغراض الحفاظ على سريتها. سوف يتم الاحتفاظ بهذه المعلومات لمدة ست سنوات من تاريخ موافقتك على الاشتراك بهذه الدراسة ثم سوف تتلف بالطريقة المناسبة.

يعتبر الاشتراك في هذه الدراسة اراديا بحثا:

يجب ان تكون مشاركتك في هذه الدراسة مشاركة طوعية بالكامل. قرارك، سواء بالموافقة على المشاركة في الدراسة أو الرفض، سوف لن تؤثر على علاقتك الحالية أو المستقبلية مع الاطباء، افراد الطاقم التمريضي الآخرين، أو أي جهة أخرى داخل أو خارج المستشفى، أو على علاقتك بجامعة ووريك. اذا وافقت على الاشتراك في هذه الدراسة فإنك تستطيع لاحقا الانسحاب من الدراسة أثناء المراقبة، و قبل أو أثناء المقابلة بدون ان يؤثر ذلك على عليك بأي طريقة من الطرق. في حال قررت الانسحاب من الدراسة بعد ان تكون قد بدأت، سوف لن يتم استخدام أي معلومة جمعت منك قبل قرار الانسحاب و سوف يتم اتلافها فورا بالطريقة المناسبة.

للاتصال و الاستفسار:

اسم الباحثة: ميادة دعبس
إذا كان لديك أي استفسار، الرجاء طرحه الآن. إذا تولد لديك أي سؤال أو استفسار لاحقا، يرجى الاتصال بي شخصيا أثناء تواجدي بالمشفى أو الاتصال بي على رقم الهاتف: 00962-777-994854

المشرفين على الدراسة هم:

د. كيت سيرز

عضو هيئة البحث التمريضي/ الكليه الملكية البريطانية للتمريض
رئيس مركز البحوث التمريضية/ كلية الدراسات الصحية و الاجتماعية
جامعة ووريك

هاتف: 0044-24-7615

فاكس: 0044-24-76150643

د. لورين بلاكستر

كلية الدراسات الصحية و الاجتماعية
جامعة ووريك

هاتف: 0044-24-76574098

فاكس: 0044-24-76524415

أو بإمكانك الاتصال بجامعة ووريك على العنوان التالي:

School of Health and Social Studies
University of Warwick
www.warwick.ac.uk
CV4 7AL
Coventry
United Kingdom

سوف يتم تزويدك بنسخة من هذا النموذج. الرجاء الاحتفاظ به.

نسخة الباحثة

نموذج الموافقة على الاشتراك

في دراسة

"ما هي العوامل المؤثرة على عملية ادارة الالم بعد العمليات عند مرضى الجراحة البالغين في المستشفيات الاردنية؟"

بنود المشاركة بالدراسة:

الرجاء وضع اشارة (✓) بجانب كل بند توافق عليه:

☐
☐
☐
☐
☐

- قرأت المعلومات الواردة في هذا الاتفاق و فهمتها فهما كاملا.
- جميع استفساراتي تم الاجابة عليها بوضوح.
- أشهد أنني أبلغ من العمر أكثر من 18 عاما.
- أمنح موافقتي على تسجيل المقابلة تسجيلا صوتيا
- أنا أوافق على المشاركة في هذه الدراسة

..... التاريخ

..... توقيع المشارك

..... اسم المشارك

..... التاريخ

..... توقيع الباحثة

نسخة المشارك

نموذج الموافقة على الاشتراك

في دراسة

" ما هي العوامل المؤثرة على عملية ادارة الالم بعد العمليات عند مرضى الجراحة البالغين في
المستشفيات الاردنية؟"

بنود المشاركة بالدراسة:

الرجاء وضع اشارة (√) بجانب كل بند توافق عليه:

☐
☐
☐
☐
☐

- قرأت المعلومات الواردة في هذا الاتفاق و فهمتها فهما كاملا.
- جميع استفساراتي تم الاجابة عليها بوضوح.
- أشهد انني أبلغ من العمر أكثر من 18 عاما.
- أمنح موافقتي على تسجيل المقابلة تسجيلا صوتيا
- أنا أوافق على المشاركة في هذه الدراسة

..... التاريخ

..... توقيع المشارك

..... اسم المشارك

..... التاريخ

..... توقيع الباحثة

Appendix Three (B.1)

Information Letter and consent form (Staff Nurses-English version)

CONSENT FORM
(REGISTERED STAFF NURSE)
THE UNIVERSITY OF WARWICK

What issues influence postoperative pain management in Jordanian hospitals?

I am conducting a study about *factors influence postoperative pain management among adult patients in surgical wards in Jordanian hospitals*. You are invited to participate in this research. You are invited to take part in this study because you are a registered staff nurse, have graduated from one of the Jordanian universities qualified with BSc in nursing, have experience in working with surgical patients, and might enrich the research findings regarding possible issues influencing postoperative pain management. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by:

Name of researcher: Mayada Daibes,
Name of advisor: Prof. Kate Seers & Dr. Loraine Blaxter
Department: School of health and Social Studies, The University of Warwick, United Kingdom.

Background Information:

The purpose of this study is to identify potential factors influencing postoperative pain management among adult patients in Jordanian hospitals.

Procedures:

If you agree to be in this study, I will arrange for observations in the ward you are working in to observe the general nursing practices, especially those related to pain management process postoperatively. Then, arrangements will be done for an interview with you about possible factors that might hinder or facilitate pain management process as well as your experience in pain management. This interview might last up to one hour. Upon your permission, interviews will be recorded using audio-digital recorder to help keep attention to what you say. If you refuse recording the interview, I will write down notes on interview papers.

Risks and Benefits of Being in the Study:

This study has no physical risks. It also does not include any type of medical or pharmacological interventions. When you feel being threatened or discomfort because of participating in this study, you have a full right to withdraw temporarily or permanently from this study.

Page -1-

Confidentiality:

The records of this study will be kept confidential. In any sort of report I publish, I will not include information that will make it possible to identify you in any way. Only initials of your name will be asked from you during the interview or data collection. Other data related to you such as your rank (if working in a military hospital, or years of experience if working in a governmental hospital), full interviews records, Audio taped interviews, and other personal information will be stored in encrypted secured files whether as a software or hardware for six years and then will be damaged as appropriate.

Voluntary Nature of the Study:

Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with doctors, other nurses, any other part in the hospital, or with the University of Warwick. If you decide to participate, you are free to withdraw at any time before or during observation or interview without affecting you in any way. Should you decide to withdraw; data collected about you will not be used for the purpose of the research and will be damaged immediately as appropriate.

Contacts and Questions

My name is *Mayada Daibes*. You may ask any questions you have now. If you have questions later, you may contact me in person while be in the hospital or at 00962-777994854

My advisors' names are:

1. Professor Kate Seers
Director, RCN Research Institute
School of Health and Social Studies
The University of Warwick
Coventry, CV4 7AL
Tel: 024 7615 0614
Fax: 024 7615 0643
2. Dr. Loraine Blaxter
Institute of Health,
School of Health and Social Studies,
The University of Warwick,
Coventry, CV4 7AL

Tel: +44 (0)24 7657 4098
Fax: +44 (0)24 7652 4415

You may also contact:

School of Health and Social Studies
University of Warwick
www.warwick.ac.uk
CV4 7AL
United Kingdom

You will be given a copy of this form to keep for your records.

Statement of Consent

Please tick beside the sentence to which you grant your consent:

I have read the above information.

☐

My questions have been answered to my satisfaction.

☐

I am at least 18 years of age.

☐

I grant my permission to record the interview by an audio-digital recorder.

☐

I consent to participate in the study.

☐

Signature of study Participant

Date

Print Name of Study Participant

Signature of Researcher

Date

Participant's copy

Statement of Consent

Please tick beside the sentence to which you grant your consent:

I have read the above information.

☐

My questions have been answered to my satisfaction.

☐

I am at least 18 years of age.

☐

I grant my permission to record the interview by an audio-digital recorder.

☐

I consent to participate in the study.

☐

Signature of study Participant

Date

Print Name of Study Participant

Signature of Researcher

Date

Appendix Three (C)

Information letter and consent form (Relatives-Arabic version)

نموذج الموافقة على الاشتراك في دراسة

" ما هي العوامل المؤثرة على عملية ادارة الالم بعد العمليات عند مرضى الجراحة البالغين في
المستشفيات الاردنية؟"
جامعة ووريك
(قريب مريض لجراحة)

سوف تقوم الباحثة بدراسة العوامل التي قد تؤثر على عملية إدارة الألم بعد العمليات عند مرضى الجراحة البالغين في المستشفيات الأردنية. أنت/ أنتي مدعوة للمشاركة في هذه الدراسة. تمت دعوتك لتشارك في هذه الدراسة لأنك تبلغ من العمر أكثر من 18 عاماً، ولأنك/أحدى اقرباء مريض جراحة ، ومشاركتك و أرائك قد تغني نتائج هذه الدراسة .

الرجاء قراءة المعلومات المذكورة لاحقاً. بإمكانك طرح أي استفسار عن أي شيء متعلق بالدراسة قبل الموافقة على الاشتراك الطوعي في هذه الدراسة.

من سيقوم بإجراء الدراسة:

اسم الباحث: ميادة دعبس.
المشرفين على الدراسة: د. كيت سيرز
د. لورين بلاكستر
اسم الكلية/الجامعة: كلية الأبحاث الصحية و الاجتماعية/ جامعة ووريك/ المملكة المتحدة

هدف الدراسة:

هدف هذه الدراسة هو دراسة العوامل التي قد تؤثر على عملية إدارة الألم بعد العمليات عند مرضى الجراحة البالغين في المستشفيات الأردنية.

طريقة عمل البحث:

بناء على موافقتك الطوعية على الاشتراك في هذه الدراسة، سوف أقوم بالترتيب مبدئياً لعمل مقابلة كلامية للتحدث عن حالة قريبك الصحية بشكل عام بعد العملية وللتحدث عن أرائك بالعناية الطبية و التمريضية المقدمة له/لها لعلاج الألم المتوقع بعد العملية في حال حصوله. قد تستمر هذه المقابلة لمدة تصل الى ساعة. إذا شعرت بأنك تود تأجيل المقابلة أو استكمالها في وقت آخر، سوف اعود لاحقاً و أكمل معك المقابلة التي كنا قد بدأناها. بناء على موافقتك المسبقة، سوف يتم تسجيل المقابلة صوتياً حتى تتمكن الباحثة من الانتباه لكل ما تقوله و تجنب فقدان أي معلومة أثناء حديثك. في حال رفضك لتسجيل المقابلة، سوف تقوم الباحثة بتدوين المقابلة خطياً على الورق.

فوائد ومخاطر الاشتراك في هذه الدراسة:

هذه الدراسة لا تنطوي على أي مخاطر جسدية أو مداخلات دوائية أو طبية من أي نوع. ولكن في حال شعرت بأي نوع من عدم الارتياح، لك الحق بالانسحاب الفوري من المقابلة و بالتالي من الدراسة. ان انخراطك في هذه الدراسة يشكل فائدة لنجاح هذا البحث الذي يحمل بعد تحليل نتائجه فوائد لتطوير المعرفة عن حالة ألم مرضى الجراحة بعد العمليات في المستشفيات الأردنية.

السرية:

جميع الأوراق و المعلومات المتعلقة بهذه الدراسة سوف تحفظ بطريقة تضمن سرية ما تنطوي عليه. أي نوع من النتائج التي سيتم نشرها بعد تحليل المعلومات لن تتضمن ما يشير أو يدل على صاحب أو مصدر هذه المعلومات.

فقط الأحرف الأولى من اسمك سوف تدون أثناء إجراء المقابلة أو كتابة أي ملحوظة متعلقة بك. جميع المعلومات مثل معلوماتك الشخصية، أو تسجيل المقابلة الصوتي سوف تحفظ في ملفات الكترونية ذات أرقام سرية لا يعرفها إلا الباحث. هذه الملفات سوف تخزن على أقراص مدمجة و تشطب عن جهاز الحاسب الخاص بالباحثة لأغراض الحفاظ على سريتها. سوف يتم الاحتفاظ بهذه المعلومات لمدة ست سنوات من تاريخ موافقتك على الاشتراك بهذه الدراسة ثم سوف تتلف بالطريقة المناسبة.

يعتبر الاشتراك في هذه الدراسة إراديا بحثاً:

يجب أن تكون مشاركتك في هذه الدراسة مشاركة طوعية بالكامل. قرارك، سواء بالموافقة على المشاركة في الدراسة أو الرفض لن يؤثر على علاقتك الحالية أو المستقبلية مع الأطباء، أفراد الطاقم التمريضي، أو أي جهة أخرى داخل أو خارج المستشفى، أو على علاقتك بجامعة ووريك. بالإضافة إلى ذلك، إن قرارك سواء بالموافقة أو الرفض سوف لن يؤثر على شكل و نوعية العناية المقدمة لك مستقبلاً أو لقرينك المريض حالياً و مستقبلاً. إذا وافقت على الاشتراك في هذه الدراسة فإنك تستطيع لاحقاً الانسحاب من الدراسة أثناء المراقبة، و قبل أو أثناء المقابلة بدون أن يؤثر ذلك على العناية المقدمة لك. في حال قررت الانسحاب من الدراسة بعد أن تكون قد بدأت، سوف لن يتم استخدام أي معلومة جمعت منك قبل قرار الانسحاب و سوف يتم إتلافها فوراً بالطريقة المناسبة.

للاتصال و الاستفسار:

اسم الباحثة: ميادة دعبس
إذا كان لديك أي استفسار، الرجاء طرحه الآن. إذا تولد لديك أي سؤال أو استفسار لاحقاً، يرجى الاتصال بي شخصياً أثناء تواجدي بالمشفى أو الاتصال بي على رقم الهاتف: 00962-777-994854

المشرفين على الدراسة هم:

د. كيت سيرز
عضو هيئة البحث التمريضي/ الكليه الملكية البريطانية للتمريض
رئيس مركز البحوث التمريضية/ كلية الدراسات الصحية و الاجتماعية
جامعة ووريك
هاتف: 0044-24-7615
فاكس: 0044-24-76150643

د. لورين بلاكستر
كلية الدراسات الصحية و الاجتماعية
جامعة ووريك
هاتف: 0044-24-76574098
فاكس: 0044-24-76524415

أو بإمكانك الاتصال بجامعة ووريك على العنوان التالي:

School of Health and Social Studies
University of Warwick
www.warwick.ac.uk
CV4 7AL
Coventry
United Kingdom

سوف يتم تزويك بنسخة من هذا النموذج. الرجاء الاحتفاظ به.

نموذج الموافقة على الاشتراك
في دراسة

" ما هي العوامل المؤثرة على عملية ادارة الالم بعد العمليات عند مرضى الجراحة البالغين في
المستشفيات الاردنية؟"

بنود المشاركة بالدراسة:

الرجاء وضع إشارة (✓) بجانب كل بند توافق عليه:

☐
☐
☐
☐
☐

- قرأت المعلومات الواردة في هذا الاتفاق و فهمتها فهما كاملا.
- جميع استفساراتي تم الاجابة عليها بوضوح.
- أشهد انني ابلغ من العمر اكثر من 18 عاما.
- أمنح موافقتي على تسجيل المقابلة تسجيلا صوتيا.
- أنا أوافق على المشاركة في هذه الدراسة.

التاريخ

توقيع المشارك

اسم المشارك

التاريخ

توقيع الباحثة

سوف يتم تزويدك بنسخة من هذا النموذج. الرجاء الاحتفاظ به.

نسخة المشارك

نموذج الموافقة على الاشتراك
في دراسة

" ما هي العوامل المؤثرة على عملية ادارة الالم بعد العمليات عند مرضى الجراحة البالغين في
المستشفيات الاردنية؟"

بنود المشاركة بالدراسة:

الرجاء وضع اشارة (√) بجانب كل بند توافق عليه:

☐
☐
☐
☐
☐

- قرأت المعلومات الواردة في هذا الاتفاق و فهمتها فهما كاملا.
- جميع استفساراتي تم الاجابة عليها بوضوح.
- أشهد انني ابلغ من العمر اكثر من 18 عاما.
- أمتح موافقتي على تسجيل المقابلة تسجيلا صوتيا.
- أنا أوافق على المشاركة في هذه الدراسة.

التاريخ-----

توقيع المشارك-----

اسم المشارك-----

التاريخ-----

توقيع الباحثة-----

Appendix Three (C.1)

Information letter and consent form (Relatives-English version)

CONSENT FORM
(FAMILY MEMBERS/RELATIVES)
THE UNIVERSITY OF WARWICK

What issues influence postoperative pain management in Jordanian hospitals?

I am conducting a study about *issues that might influence postoperative pain management among adult patients in surgical wards in Jordanian hospitals*. I invite you to participate in this research. You are invited to participate in this study because you are a relative of a patient who is currently admitted to the hospital to undergo a surgery. Your participation may enrich the research findings regarding the postoperative care presented to your relative to facilitate his/her pain management. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by:

Name of researcher: Mayada Daibes,
Name of advisor: Prof. Kate Seers & Dr. Loraine Blaxter
Department: School of health and Social Studies, The University of Warwick, United Kingdom.

Background Information:

The purpose of this study is to identify potential factors influencing postoperative pain management among adult patients in Jordanian hospitals.

Procedures:

If you agree to be in this study, I will initially arrange for an interview with you to talk about your relative's general postoperative condition and your views regarding care introduced to his/her. This interview might last up to one hour. If you felt exhausted, I would come back another time and see whether you would like to continue the interview. If you agreed, interviews will be recorded using audio-digital recorder to help keep attention to what you say. If you do not agree to record the interview, I will write down notes on the interview paper.

Risks and Benefits of Being in the Study:

This study has no physical risks. However, if you found that you might experience any threat of any type, please inform me or you can simply withdraw from the study at any time.

Confidentiality:

The records of this study will be kept confidential. In any sort of report I publish, I will not include information that will make it possible to identify you in any way. Only initials of your name will asked from you during the interview or data collection. Other data related to you such as personal data, full

Page -1-

interviews records, and Audio taped interviews will be stored in encrypted secured files whether as a software or hardware for six years, then will be damaged as appropriate.

Voluntary Nature of the Study:

Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect the care introduced to your relative; will not affect your current or future relations with doctors, nurses, or any other part in the hospital or the University of Warwick. If you decide to participate, you are free to withdraw at any time before or during observation or interview. Should you decide to withdraw; data collected about you will not be used for the purpose of the research and will be damaged immediately as appropriate.

Contacts and Questions

My name is *Mayada Daibes*. You may ask any questions you have now. If you have questions later, you may contact me in person while be in the hospital or at 00962-777-994854

My advisors' names are:

1. Professor Kate Seers
Director, RCN Research Institute
School of Health and Social Studies
The University of Warwick
Coventry, CV4 7AL
Tel: 024 7615 0614
Fax: 024 7615 0643
2. Dr. Loraine Blaxter
Institute of Health,
School of Health and Social Studies,
The University of Warwick,
Coventry, CV4 7AL

Tel: +44 (0)24 7657 4098
Fax: +44 (0)24 7652 4415

You may also contact:

School of Health and Social Studies
University of Warwick
www.warwick.ac.uk
CV4 7AL
United Kingdom

You will be given a copy of this form to keep for your records.

Statement of Consent

Please tick beside the sentence to which you grant your consent:

I have read the above information.

☐

My questions have been answered to my satisfaction.

☐

I am at least 18 years of age.

☐

I grant my permission to record the interview by an audio-digital recorder.

☐

I consent to participate in the study.

☐

Signature of study Participant

Date

Print Name of Study Participant

Signature of Researcher

Date

Participant's copy

Statement of Consent

Please tick beside the sentence to which you grant your consent:

I have read the above information.

☐

My questions have been answered to my satisfaction.

☐

I am at least 18 years of age.

☐

I grant my permission to record the interview by an audio-digital recorder.

☐

I consent to participate in the study.

☐

Signature of study Participant

Date

Print Name of Study Participant

Signature of Researcher

Date

Appendix Three (D)

Information letter and consent form (Physicians-English version only)

CONSENT FORM
(PHYSICIANS)
THE UNIVERSITY OF WARWICK

What issues influence postoperative pain management in Jordanian hospitals?

I am conducting a study about *factors influence postoperative pain management among adult patients in surgical wards in Jordanian hospitals*. I invite you to participate in this research. You are invited to take part in this study because you are a surgeon who have an experience in working with surgical patients and might enrich the research findings regarding possible issues influencing postoperative pain management. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by:

Name of researcher: Mayada Daibes,
Name of advisor: Prof. Kate Seers & Dr. Loraine Blaxter
Department: School of health and Social Studies, The University of Warwick, United Kingdom.

Purpose of the study:

The purpose of this study is to identify potential factors influencing postoperative pain management among adult patients in Jordanian hospitals.

Procedures:

If you agree to be in this study, I will observe all medical interventions that are done for some surgical patients postoperatively as well as the verbal and non-verbal communication between you and other nurses and patients regarding pain management process. Then, I will arrange for an interview with you about possible factors that might hinder or facilitate pain management process as well as your experience in pain management. This interview might last up to one hour. Upon your permission, interviews will be recorded using tape recorder to help keep attention to what you say. If you refuse recording the interview, I will write down notes on the interview paper.

Benefits and risks of participating in the Study:

This study has no physical risks. This study does not include any physical or pharmacological intervention of any type.

Page -1-

Confidentiality:

The records of this study will be kept confidential. In any sort of report I publish, I will not include information that will make it possible to identify you in any way. Only initials of your name will be asked from you during the interview or other data collection. Other data related to you such as your rank (if working in a military hospital, or years of experience if working in a governmental hospital), full interviews records, and audio-digital recorded interviews will be stored as encrypted secured files whether as a software or hardware for six years and then will be damaged as appropriate.

Voluntary Nature of the Study:

Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with other doctors, nurses, any other part in the hospital, or with the University of Warwick. If you decide to participate, you are free to withdraw at any time before or during observation or interview. Should you decide to withdraw; data collected about you will not be used for the purpose of the research and will be damaged immediately as appropriate.

Contacts and Questions

My name is *Mayada Daibes*. You may ask any questions you have now. If you have questions later, you may contact me in person while be in the hospital or at 00962-777994854

My advisors' names are:

1. Professor Kate Seers
Director, RCN Research Institute
School of Health and Social Studies
The University of Warwick
Coventry, CV4 7AL
Tel: 024 7615 0614
Fax: 024 7615 0643
2. Dr. Loraine Blaxter
Institute of Health,
School of Health and Social Studies,
The University of Warwick,
Coventry, CV4 7AL

Tel: +44 (0)24 7657 4098
Fax: +44 (0)24 7652 4415

You may also contact:

School of Health and Social Studies
University of Warwick
www.warwick.ac.uk
CV4 7AL
United Kingdom

You will be provided with a copy of this form to keep for your records.

CONSENT FORM

What issues influence postoperative pain management in Jordanian hospitals?

Statement of Consent

Please tick beside the sentence to which you grant your consent:

I have read the above information.

☐

My questions have been answered to my satisfaction.

☐

I am at least 18 years of age.

☐

I grant my permission to record the interview by audio-digital recorder.

☐

I consent to participate in the study.

☐

Signature of study Participant

Date

Print Name of Study Participant

Mayada Daibes
Signature of Researcher

Date

CONSENT FORM

What issues influence postoperative pain management in Jordanian hospitals?

Statement of Consent:

Please tick beside the sentence to which you grant your consent:

I have read the above information.

☐

My questions have been answered to my satisfaction.

☐

I am at least 18 years of age.

☐

I grant my permission to record the interview by audio-digital recorder.

☐

I consent to participate in the study.

☐

Signature of Study Participant

Date

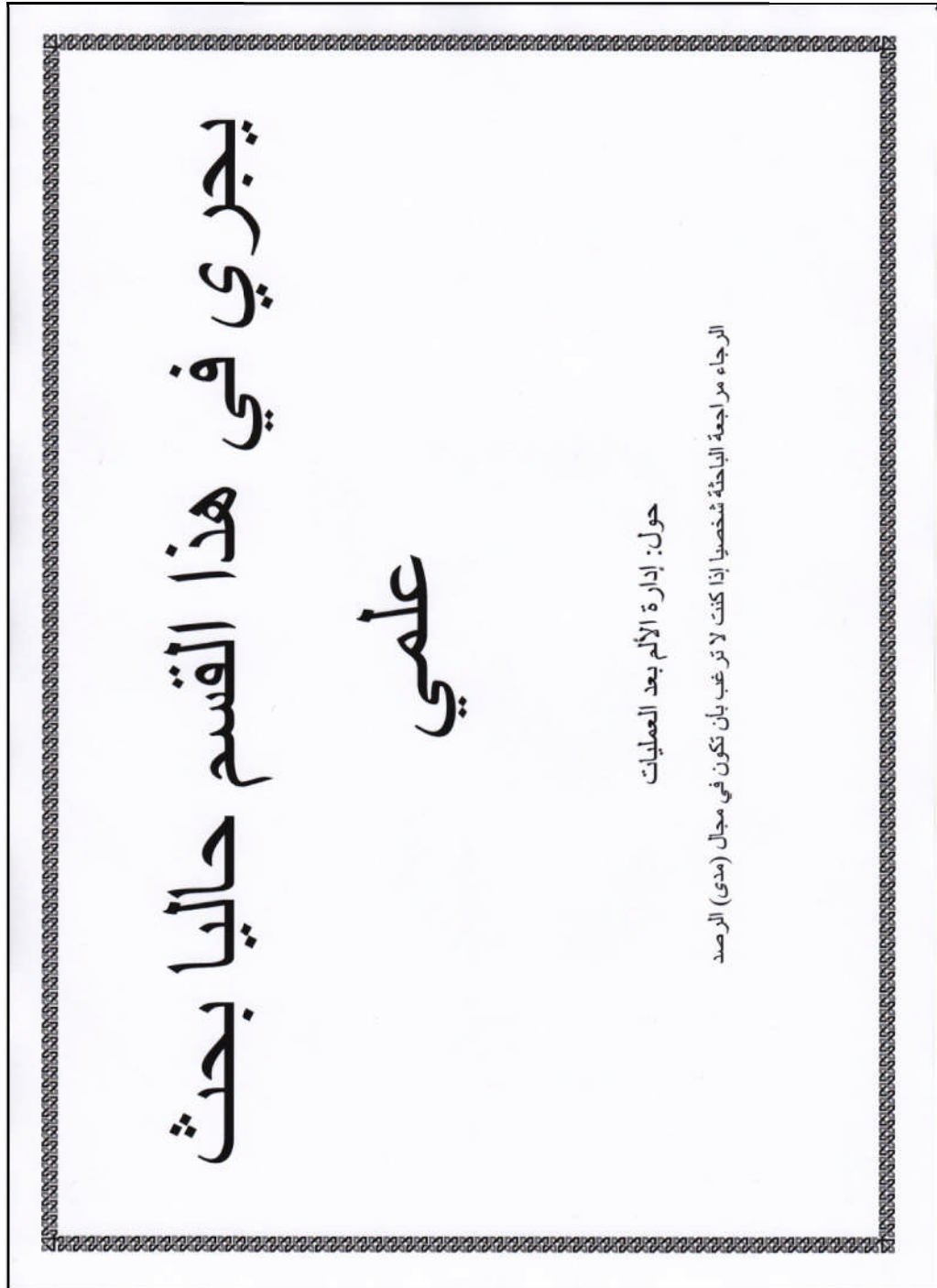
Name of Study Participant

Signature of Researcher

Date

Appendix Four

Sample of poster stuck on patients' beds, doors of patients' rooms clarifying that an observation is in progress.



Appendix Five

The researcher's access card to the Military Hospital, clarifying the beginning and ending dates of the research, and the extension for one month



Sample of sheets used for recording observation notes

1

Appendix Seven

Themes of topic guides of all participants interviews

1. Topic guide of health professionals' (nurses & doctors) interviews:

- a. Professional's role in pain management
- b. Factors influence professionals' role in pain management: Helping/hindering factors of effective pain management; nurse-doctor relationship; challenges in professionals' relationship.
- c. Socio-cultural factors: influence of patients' gender on professionals' assessment, intervention practices, making decisions; Effect of visitors on professionals' practices.
- d. Organizational factors: Effect of legislations and policies on pain management practices and decisions; Effect of rank on professional-patients relationship, as well as inter-professional relationships; Effect of physical layout on professionals' practices; Effect of Job satisfaction on professionals' pain practices.
- e. Pain management education: Educational needs.

2. Topic guide for patients' interviews:

- a. Pain and distress prevalence, using items of NRS³, in addition to some questions regarding patients' subjective description of pain experience and related events, their practices during experiencing pain
- b. Communication of pain: Willingness to communicate pain to others, especially to health professionals; Patients' expectations from professionals during pain experiences; Influence of professionals' gender on patients' expectations; influence of professionals' gender on patients' willingness to communicate pain; patients' preference of professionals' gender; influence of professionals' rank/ classification on patients' willingness to report pain.
- c. Socio-culture: Perspectives regarding influence of Jordanian traditions and customs on patient-professional relationship in pain; Patients' perspective of non-pharmacologic pain management interventions applied by professionals of same or opposite genders, such as massage, supportive touch, and humour.
- d. Preoperative education: information provided preoperatively about expected pain postoperatively, or the available pain relief interventions
- e. Patient's participation in pain management process, and decision making

³ However, measuring pain and distress, using a ruler, does not solely indicate quantifying these subjective data. Rather, they were used as indicators of patient's pain severity and distress.

3. Topic guide for relatives' interviews:

- a. Ordinary family members' practices during pain experiences.
- b. Patient's and relative's practices in communicating pain when experiencing pain out of the hospital.
- c. Relatives perspective of factors influence the patient's or people's, in general, willingness to communicate pain in Jordanian community/in hospitals;
- d. Professional-relative relationship: Description, expectations
- e. Satisfaction regarding presented pain care: Expectations, suggestions of further care interventions.

Appendix Eight (A)

Interview topic guide (Patients)

Date/Time of interviews-----

Date of operation-----

Name of operation:-----

Patient No. -----

Age-----

Gender: M F Marital status-----

Main question	Prompts
Can you tell me about any pain you have had since your operation? انا حابة احكي معك اليوم عن الالم (الوجع) اللي صار معك بعد العملية, بتقدر تحكي لي عن اي الم صار معك بعد العملية؟	<p>Characteristics of pain:</p> <p>How severe was the sensation of pain postoperatively? If I told you that this ruler is divided from one to ten, zero means no pain at all, and ten means agonizing pain, where do you point to describe your pain status postoperatively?)</p> <p>كم شدة المك اللي حسيت فيه بعد العملية؟ اذا حكيتلك انه هاي المسطرة مقسمة من صفر الى عشرة (صفر يعني ما في الم بالمرة و عشرة تشير ال اشد الم يمكن تصوره, انتة وين عالمسطرة بتأشر عشان توصف شدة المك</p>
	How severe is the sensation of pain now?
	How distressful is the sensation of pain? On the same ruler, zero means no distress and ten means extremely distressing. فيه ناس بيكون الالم معاهم ضعيف بس بيشكلهم مضايقة شديدة. من صفر (ما في مضايقة) الى عشرة على المسطرة (ضيق شديد), وين بتأشر عشان توصف المضايقة و الضغط النفسي المصاحب لالمك
	How does the pain change through the time since the operation until now? If the patient did not remember, ask him /her about the last 24 hours. بتقدر تحكي لي كيف تغيرت شدة الالم من وقت العملية حتى الان؟ (يعني بقي الالم بنفس الشدة و لا تغير؟ اذا تغيرت شدة الالم صف لي التغير
Usually, when you feel pain not in hospital, what do you do? عادة لما يصيبك الم (وجع) شو بتتصرف (شو بتعمل؟	<p>Communication of pain:</p> <p>How do you feel about telling others about your pain? Why? كيف بتحس لما تخبر حدا عن المك؟ لماذا؟</p> <p>Did you tell others (nurses, doctors, relatives) about your pain? Yes/No? حكيت لحدا من التمريض، الاطباء، قرايبك او مرافقك عن الوجع اللي حسيت فيه بعد العملية؟ (نعم لا)؟</p>
	Can you say a bit more about that?

	<p>معلش تحكي اكثر عن هذا الموضوع؟</p>
	<p>Does whether the nurse is male or female influence how you feel about telling them about your pain? Whom do you prefer telling about your pain, male or female nurses?</p> <p>هل كون الممرض ذكر او انثى يؤثر على رغبتك باخبارهم عن المكن؟ لمن تفضل انك تحكي و تشكي ألك، للممرضة او للممرض؟ ليش؟ اعتمادا على ايش؟</p>
	<p>What did you expect from nurses when you felt pain postoperatively?</p> <p>لما صار عندك الم بعد العملية، شو توقعت\طمحت من الممرضات\الممرضين؟</p>
	<p>To what extent your expectations were satisfied.</p> <p>لاي درجة\احد طموحك او توقعاتك تحققت؟</p>
	<p>What if the nurse is a man (woman)?</p> <p>انته حكيتلي عن توقعاتك من الطاقم التمريضي...لو كانت الممرضة انثى\ارجل..ما هي توقعاتك؟</p>
	<p>Does it make difference to you to be cared of by a man or woman? If yes how? If no, give views.</p> <p>هل هناك فرق بالنسبة لك اذا اللي اشرف على العناية فيك رجل\امراة؟</p>
	<p>Do you think that cultural traditions or customs affect your relationship with nurses (doctors) regarding your pain? If yes how? If no, give views.</p> <p>هل تعتقد انه العادات و التقاليد بتأثر عاي علاقتك مع الممرضين و الاطباء (خلال وجود الالم بعد العملية؟)</p>
	<p>How would you interpret a nurse's (doctor) (of opposite gender) supportive humour or touch for you?</p> <p>مثلا، اذا احدى افراد الطاقم التمريضي (من نفس الجنس) حاول المزاح معك او حاول يهدي عليك بالطبوبة كتفك او على يدك او حتى يمزح معك بخفة... كيف رح نفسر هالشي؟</p>
	<p>How would you interpret a nurse's (doctor) (of same gender) supportive humour or touch for you?</p> <p>مثلا، اذا احدى افراد الطاقم التمريضي (من الجنس الاخر) حاول المزاح معك او حاول يهدي عليك بالطبوبة على كتفك او يمسك ايدك او غيره...كيف رح تفسر هذا الشي؟</p>
	<p>Did any of healthcare team members talk to you about available pain relief interventions to you? If yes,</p> <p>هل تحدثت اي من الطاقم الطبي او التمريضي عن اي علاج او طريقة للتعامل مع الالم اذا حدث بعد العملية؟</p>
	<p>Do you feel you have a part in your pain management?</p> <p>هل كان لك دور في علاج المكن الذي حصل معك بعد</p>

	<p>العملية؟</p> <p>What is your role in managing your pain? طبيب احكي لي شو كان دورك بعلاج المك اللي حصل معك بعد العملية (يعني بشو شاركت)؟</p>
<p>Some patients may bring some herbs for example or other traditional things to deal with their pain; did you bring anything similar? If yes, what?</p> <p>بعض المرضى يحضروا اعشاب (على سبيل المثال) لانهم بيعتقدوا انها يمكن تفيدهم بتخفيف المهم.. البعض الآخر بيحب مصحف.. انت هل احضرت معك اشياء مماثلة حتى تتعامل مع المك؟</p>	<p>If yes, such as what? مثل ايش</p> <p>Why you brought them with you? لماذا احضرتهم؟</p>
<p>What happened if you have experienced pain postoperatively?</p> <p>معلش تحكي لي شو صار لما حسيت بالالم بعد العملية؟</p>	
<p>Did anybody talk to you about pain and its management before operation? If yes, what? If No, would this have been helpful?</p> <p>هل تحدثت اليك احد من الطاقم التمريضي او الطبي او اي احد اخر عما هو متوقع انه يحدث معك بعد العملية؟ (حدا حكاك قيل العملية انه يمكن تحس بالالام بعد العملية؟ اذا نعم: ايش حكاك عن الالم المتوقع؟ هل تحدثوا اليك عن كيفية علاج الالم المتوقع بعد العملية اذا ما حكاك عن احتمالية حدوث الم معك بعد العملية.. هل بتتوقع انه لو انت على الاقل تخبرت كان هذا الشي رح يساعدك؟؟؟ كيف</p>	
<p>Do you feel the rank of the nurse (doctor) influences the way you deal with them? if yes, how?</p> <p>هل تشعر ان رتبة الممرضه/الطبيب تؤثر على الطريقة التي تتعامل معهم فيها (يعني هل هناك فرق بتعاملك بين الافراد اذا كانت رتبتهن مختلفة) طيب بالنسبة لالمك؟</p>	<p>Rank (Especially in military hospital)</p> <p>Willingness to communicate pain. سؤال عن رغبة المريض بالافصاح عن المة</p> <p>Expectations (توقعاتك)</p>
<p>Some patients may find it difficult to dealing with nurses (doctors) of different ages; does this make a difference to you?</p> <p>بعض المرضى يمكن يلاقوها صعبة يتعاملو مع ممرضات او ممرضين من اعمار مختلفة... هل عمر الممرض ييشكل فرق بالنسبة لك؟</p>	<p>Age (Specially in governmental hospital)</p> <p>Willingness to communicate pain</p> <p>Expectations (توقعاتك)</p>
<p>Finally, if you had to tell someone else what pain is, what would you say?</p> <p>طبيب اذا حكيتك تحكي لي شو الالم بالنسبة لك... شو بتحكي؟ ما هي نظرتك للالم؟</p>	
<p>Is there anything we have not discuss you would like to add?</p> <p>هل هناك اي شي لم نناقشه و تريد التحدث عنه؟ هل هناك شي تناقشنا فيه و تريد التحدث اكثر عنه؟</p>	

Appendix Eight (B)

Interview topic guide (Staff nurses)

Date/Time of interview-----

Participant No.:----- Age: ----- Gender: M F Marital status----

Experience (Yrs)----- Experience (In surgical setting) -----

Rank:-----/NA Pregnant: Yes/ No

I would like to tell you that this study is not for work evaluation. There is no right or wrong answers.

Main question	prompts
First of all would tell me what is pain for you? مكن تعرفي الالم بالنسبة لك؟ هل لك ان تتحدث عن ما هو الالم بالنسبة لك؟	
I would like to talk with you today about postoperative pain management; first tell me about your role in managing pain postoperatively, please. اليوم اود الحديث اليك عن ادارة الالم بعد العملية عند مرضى الجراحة. هل لك ان تخبرني عن درورك في عملية ادارة الالم بعد العملية المرضى الجراحة؟	How do you decide whether a patient has pain ? كيف تحدد اذا كان المريض معه الم او لا؟
	How do you assess the patient for postoperative pain? كيف تفحص المريض للالم بعد العملية؟
	What are indicators you take into account in making decisions regarding type of intervention to manage pain? ما هي الاشياء التي تأخذها بعين الاعتبار عندما تحدد نوع المداخلات التمرضية او اي علاج لادارة الم مريض ما بعد العملية؟
	Tell me about sorts of things you use in pain management? What about other nurses if you know? ما هي الطرق (او بمعنى الاساليب, الاشياء, المداخلات) التي تستخدمها لادارة الم مريض ما بعد العملية؟ ماذا عن افراد الطاقم التمريضي الاخرين العاملين معك بالقسم؟
	What are indicators you take into account in making decisions regarding dose of interventions to manage pain? ما هي الاشياء (العوامل) التي تأخذها بعين الاعتبار عندما تحدد جرعة المداخلات التمرضية او علاج ما لادارة الالم عند مريض ما بعد العملية؟
	How do you determine when to give a painkiller post-operation? كيف تحدد او تقرر متى تعطي المسكن للمرضى بعد العمليات؟
From your experience, tell me about factors, if any, which may influence your role in postoperative pain management. من تجربتك بالعمل..هل لك ان تخبرني عن عوامل تؤثر على دورك في ادارة الالم للمرضى بعد العمليات	(e.g. factors related to patients, doctors, nurses, patients' families, organization, culture, others)
From your experience, tell me what you think helps pain management process, please من خلال تجربتك العملية, ما هي العوامل	(e.g. factors related to patients, doctors, nurses, patients' families, organization, culture, others)

<p>(باعتقادك) التي قد تساعد على ادارة الالم بشكل فعال؟ ما هي العوامل التي تحفز دورك في عملية ادارة الالم عند المرضى بعد العمليات؟</p>	
<p>From your experience, tell me what you think hinder pain management process, please</p> <p>من خلال تجربتك العملية، ماذا تعتقد هي العوامل التي قد تهدد على ادارة الالم بشكل فعال؟ ما هي العوامل التي تهدد (تنشط) دورك في عملية ادارة الالم عند المرضى بعد العمليات؟</p>	<p>(e.g. factors related to patients, doctors, nurses, patients' families, organization, culture, others)</p> <p>Factors influence nurses' role in pain management:</p> <p>Professional relationships How do you describe your relationship with doctors working with you in making decisions regarding pain? كيف تصف علاقتك بالاطباء الذين يعملون معك عند اتخاذ القرارات لعلاج الالم او عند تحديد المداخلات اللازمة لادارة الالم؟</p> <p>Do you and doctors discuss decisions regarding patients' pain management? هل تتناقش انت و الطبيب في قرارات والاوامر الطبية او المداخلات اللازمة لادارة الالم عند مريض ما بعد العملية؟</p> <p>Are there any challenges arise when doctors and staff discuss decisions regarding postoperative pain management? if yes, like what? هل هناك اي تحديات\اصدامات\مشاكل\تعقيدات تواجهها عند النقاش مع الطبيب على القرارات\الاوامر\المداخلات لادارة الالم عند مريض بعد العملية؟</p> <p>What happens if a patient is in severe pain while the doctor is out of the hospital or unavailable for any reason? ماذا يحدث اذا كان هناك مريض يشكو من الالم الشديد في وقت لم يكن الطبيب فيه موجود بالقسم او كان من الصعب تواجده مع المريض في ذلك الوقت لظرف اخر(مثال:كان خارج المستشفى؟</p> <p>Do you feel you need any further education about pain management? If yes, like what? If no, what about other nurses? هل تشعر انك بحاجة الى معلومات اكثر عن كيفية ادارة الالم بشكل فعال؟ اذا نعم مثل ماذا؟ اذا لا، ماذا عن الممرضين الاخرين؟</p>
<p>Do you think the cultural traditions or customs influence your role in pain management? if yes, how? If no, give views/ هل تعتقد ان العادات و التقاليد تؤثر على دورك في ادارة الالم بعد العمليات؟ اذا نعم، كيف؟ اذا لا، ما هي وجهة نظرك؟</p>	<p>Socio-cultural customs and gender:</p> <p>Do you think cultural traditions or customs affect your relationships with patients and their families? If yes, how? If no, give views? هل برأيك العادات و التقاليد لها اثر على علاقتك بالمريض وعائلته؟</p> <p>Is gender an issue when making decisions regarding how to assess a patient's postoperative pain? هل جنس المريض له تأثير عندما تريد فحص المريض للالم؟</p> <p>Is gender an issue when making decisions how to intervene to manage a patient's postoperative pain? هل جنس المريض له تأثير عندما تريد تحديد نوع المداخله التمريضية او تطبيق امر الطبيب لادارة الالم عند مريض بعد العملية؟</p>

	<p>Does your gender affect your role in pain management (for example, assessment, intervention, and presented psychological support; e.g. humour or supportive touch) during different shifts?</p> <p>بشكل عام، هل تعتقد ان جنس المريض يؤثر على دورك في ادارة الالم بعد العملية (الفحص، تطبيق المداخلات او الاوامر الطبية، الدعم المعنوي و النفسي للمريض عن طريق المزاح او ان تمسك بيده مثلا للتخفيف عنه؟</p>
<p>Do you think there are any organizational factors that might influence pain management process postoperatively? (e.g. pain management policies?)</p> <p>هل تعتقد ان هناك اي شيء بشكل عام بالنسبة للمستشفى (مثل السياسات المتبعة، نظام المستشفى) يث ر على عملية ادارة الالم؟</p>	<p>Institutional factors:</p> <p>How do you think working in this hospital affect your work?</p> <p>باعتقادك، كيف يؤثر عملك في هذا المشفى على عملك كممرض في ادارة الالم؟</p> <p>Do legal legislations regarding pain medications, especially opioids, affect your decisions regarding patients' postoperative pain management? If yes, how? If no, give views?</p> <p>هل القوانين التي تتعامل مع الادوية الخاصة لعلاج الالم: مثل العقاقير الخدرة، تؤثر على قراراتك المتعلقة بكيفية ادارة الالم عمد المرضى؟</p>
<p>I have heard about some patients who behave differently with doctors and nurses because of the difference in rank? What do you think about this?</p> <p>انا سمعت عن مرضى قد يتصرفون بطريقة مختلفة مع الاطباء و التمريض حسب الرتبة العسكرية؟ هل لك ان تتحدث لي في هذا الموضوع و خصوصا عندما يتعلق الامر بالالم عند المرضى؟</p>	<p>Do you think that your rank influence patients' relationship with you regarding their pain?</p> <p>هل تعتقد انه رتبة الطبيب\الممرض تؤثر على علاقة المريض بالطبيب او الممرض؟ هل تعتقد انه اختلاف الرتبة يؤثر على قابلية المريض للافصاح عن المة امام الطبيب او الممرض؟</p> <p>Do you think that your rank influence the way nurses work with you or with others?</p> <p>بشكل عام، هل تعتقد ان اختلاف الرتبة العسكرية يؤثر على طريقة التعامل بين افراد الطاقم التمريضي مع بعضهم\او مع الاطباء.</p> <p>Do nurses behave differently with different doctors of different ranks? (regarding his/her orders?)</p> <p>هل يتعامل الممرضين\الممرضات بشكل مختلف مع الاطباء الذين يحملون رتبة اعلى من اولئك الذين يحملون رتبة اقل مثلا؟</p>
<p>Does the physical layout of the ward influence the way you work with patients? If yes, how?</p> <p>هل شكل القسم\الغرف او طريقة بناؤه تؤثر على طريقة عملك مع المرضى؟</p>	
<p>Does the number of visitors in this ward affect your work with patients? If yes, how? If no, give views.</p> <p>هل يؤثر عدد الزوار او المرافقين على عملك مع المرضى؟</p>	
<p>Do A.Ns sometimes have to take on some of the duties of the SN? why ? are there any issues arising from this?)</p> <p>هل يقوم الممرض المشارك ببعض اعمال الممرض القانوني؟ لماذا؟</p>	<p>Which shifts you prefer to work on? Why? If you did not work according to your preference, how does this affect your work during shifts you do not like to work during? Why?</p> <p>لماذا؟ على اي شفت تفضل العمل؟ اذا حصل و دامتني على شفت انتة مش حاب تداوم عليه، كيف يؤثر هذا على عملك ؟</p> <p>Does working on different shifts have any effect on the way you work with patients? If yes, how. If no, give views</p> <p>هل العمل على شفقات مختلفة (شفت النهار او السهر) لها تأثير مختلف على عملك مع المرضى؟</p>

	<p>(To H.N, S.Ns): I noticed that the bulk of S.Ns and A.Ns are put on duty at day shift (Shift A). Would you explain this? لاحظت ان هناك عدد كبير من التمريض يداوم على شفت النهار. هل يمكنك تفسير هذا</p> <p>(For female nurses in surgical male ward): I noticed that some female nurses turn their faces to the opposite direction, or leave the patient's room when the doctor exposes patient's incision. Would you talk more about this? لاحظت انه الممرضات يديرها وجوههم او يخرجوا من الغرفة لما هل لك بالحديث عن هذا يكشف الطبيب عن مريض رجل الموضوع؟</p> <p>(To S.Ns, H.N): Do you feel there is any difference between the care/ care presented to patients in the private wing and to patients in the general wing? هل تعتقد انه هناك فرق <u>يتعامل</u> التمريض مع المرضى في الجناح الخاص و اولئك في الجناح العمومي؟</p> <p>هل تعتقد انه هناك فرق <u>بالعناية المقدمة</u> لمرضى في الجناح الخاص و اولئك في الجناح العمومي؟</p> <p>Is there anything else we have not discussed you would like to add? هل هناك اي شيء تريد التحدث عنه اكثر من المواضيع التي تحدثنا عنها؟ هل هناك اي شيء اخر لم نتحدث عنه و تريد تحدث عنه؟</p>
--	--

Appendix Eight (C)

Interview topic guide (Physicians)

Date/Time of Interview:-----

Participant No.:-----

Age:-----

Gender: M F

Specialism:-----

Experience (Years):-----

Rank:-----/NA

Main question	Prompts
<p>I would like to talk with you today about postoperative pain management; first, tell me about your role in managing pain postoperatively, please.</p> <p>أود التحدث اليك اليوم عن ادارة الالم عند المرضى بعد العمليات. بالبداية, هل لك ان تخبرني عن دروك في ادارة الالم بعد العملية عند مرضى الجراحة؟</p>	<p>Role in managing pain:</p> <p>What sorts of things you order or use in pain management?</p> <p>مثل ماذا هي الاشياء التي تأمر بها لادارة الالم بعد العملية؟</p>
	<p>How do you decide whether a patient is in pain? How assess the patient for postoperative pain?</p> <p>كيف تحدد/تقرر اذا كان المريض عنده الم او لا؟ كيف تفحص المريض لتعرف انه عنده الم او لا؟</p>
	<p>What are indicators, if any, that you take into account in making orders regarding type and dose of intervention to manage pain?</p> <p>ما هي الاشياء (المؤشرات) التي تأخذها بعين الاعتبار عندما تقرر الامر الطبي اللازم لادارة الالم عند المريض بعد العملية؟</p>
	<p>What determine what sort of painkillers you prescribe for patients post operatively?</p> <p>ما هي العوامل التي تحدد نوع المسكن الذي تقرر استخدامه لعلاج المرضى بعد العمليات؟</p>
	<p>How do you determine when to give a painkiller post-operation?</p> <p>كيف تحدد متى يتم البدء باعطاء المريض مسكن بعد العمليات؟</p>
<p>You talked at the beginning about the role you have in managing your pain, tell me what factors you think may influence your role in postoperative pain management?</p> <p>انتة تحدثت الي بالبداية عن دورك بادارة الالم بعد العملية لمرضى الجراحة, هل لك ان تخبرني ما هي العوامل التي (باعتقادك) قد تؤثر على هذا الدور؟</p>	
<p>From your experience, tell me what you think help pain management process, please. (E.g. factors related to nursing, patient, doctor, family, organization, others)</p> <p>من خلال تجربتك العملية, هل لك ان تخبرني عن العوامل (التي باعتقادك) قد تساعد على ادارة الالم بشكل فعال (مثال: عوامل متعلقة لاتمرير, بالطبيب, بالمريض, بعائلة المريض, المستشفى بشكل عام)؟</p>	
<p>From your experience, would you tell me what you think hinder pain management process? (from nursing perspective, patient perspective, doctor perspective, family perspective, organization perspective)</p> <p>من خلال تجربتك العملية, هل لك ان تخبرني عن العوامل (التي باعتقادك) قد تهدد (تنشط) عملية ادارة الالم بشكل فعال (مثال: عوامل متعلقة لاتمرير, بالطبيب, بالمريض, بعائلة المريض, المستشفى بشكل عام)؟</p>	<p>Factors facilitate or hinder pain management:</p> <p>Professional relationships and gender</p> <p>Who do you think is responsible for managing patients' pain postoperatively? Would you explain your point of view?</p> <p>من تعتقد برأيك انه يجب ان يكون مسؤول عن علاج الالم عند مرضى الجراحة؟</p>
	<p>Tell me what like it is working as a <u>male</u></p>

	<p>doctor in a <u>female</u> patients' ward/ <u>Female</u> nurses, please.</p> <p>هل لك ان تتحدث الي عن طبيعة العمل مع طبيبة انثى في قسم مريضات اناث مع ممرضات اناث</p>
	<p>Disregarding nurse's gender, how do you describe your relationship with nurses working with you in making decisions regarding pain?</p> <p>بغض النظر عن جنس (ذكر او انثى), كيف تصف علاقتك بافراد الطاقم التمريضي عندما تعملون لادارة الالم عند مريض معين؟</p>
	<p>Considering nurse's gender, How do you describe your relationship with nurses working with you in making decisions regarding pain?</p> <p>هل لك ان تصف لي علاقتك بافراد الطاقم التمريضي عندما يكون الممرض ذكر\انثى عندما تعملون لادارة الالم بعد العملية لمريض معين؟</p>
	<p>Do you and nurses discuss decisions regarding patients' pain management?</p> <p>هل يحدث نقاش بينك و بين التمريض على القرارات\المداخلات اللازمة لادارة الالم لمريض ما بعد العملية؟</p>
	<p>From you experience, are there any challenges arise when you make decisions regarding postoperative pain management? If yes what sorts of challenges? If no, give views?</p> <p>من خلال تجربتك العملية, هل لك ان تخبرني عن اي تحديات\اصدامات\مشاكل\معيقات تحدث عندما تتخذ قرار لادارة الالم بعد العملية عند مريض ما؟</p>
	<p>Do you think cultural traditions and customs affect your relationship with patients and their families? If yes, how? If no, give views.</p> <p>هل تعتقد انه العادات و التقاليد تؤثر على علاقتك بالمريض؟ بعائلة المريض؟</p>
	<p>Does your gender affect your role in pain management assessment, intervention, and follow up?</p> <p>هل يؤثر الجنس (ذكر او انثى) على دورك بادارة الالم بعد العمليات؟</p>
<p>Do you think there is any organizational factors that might influence pain management process postoperatively(pain management policies, system...etc)</p> <p>هل تعتقد انه هناك اي شيء بالمستشفى بشكل عام يؤثر على عملية ادارة الالم بعد العمليات؟ (نظام المستشفى, سياساته)</p>	<p>Institutional factors:</p> <p>How does working in this hospital affect your work?</p> <p>كيف يؤثر العمل بهذا المشفى على عملك ؟ على دورك بادارة الالم؟</p>
<p>I have heard about some patients who behave differently with doctors and nurses because of the difference in rank? What do you think about this?</p> <p>سمعت عن بعض المرضى الذين قد يتصرفون بطريقة مختلفة مع الاطباء و الممرضين بسبب اختلاف رتبهم العسكرية؟ هل لك ان تحدث لي عن هذا الموضوع؟</p>	<p>Do you think that your rank influence patients' relationship with you regarding their pain?</p> <p>هل تعتقد ان الرتبة العسكريه تؤثر على علاقة الممرض بالطبيب؟ (مثال: على رغبة المريض بالافصاح عن المة, التواصل مع الطبيب)</p> <p>Do you think that your rank influence the way nurses work with you or with others?</p> <p>هل تعتقد ان رتبة الطبيب العسكرية تؤثر على الطريقة التي يتعامل بها التمريض مع الطبيب او مع الاخرين؟</p>

	<p>Do nurses behave differently with different doctors of different ranks? (Regarding his/her orders?)</p> <p>هل يتعامل التمريض بطريقة مختلفة مع الاطباء الذين يحملون رتب عسكرية مختلفة (من حيث تنفيذ الاوامر, المساعدة في بعض المداخلات الطبية...الخ)</p>
<p>Is there anything else we have not discussed you would like to add?</p>	<p>هل هناك اي شيء تودا الحديث عنه اكثر من المواضيع التي تحدثن</p>

Appendix Eight (D)

Interview topic guide (Relatives)

Date/Time of interview:-----

Relationship to patient: -----

Gender: M F

Age-----

Main Question	Prompts
Usually, when you, or somebody in the family fall in pain or illness, what do you do? عادة, عندما, إنته او اي شخص من العائلة, يشعر بالمر في اي مكان, ما الذي تقوم به؟	Usually, do you express pain freely to one person than another when not in hospital? (In hospital)? If yes, who, why? If no, give views. عادة, هل تعبر (او تخبر) عن الم لك لحد معين؟ Usually, does patient express pain freely to one person than another when not in hospital? In hospital? If yes, who? Why? عادة, هل قريبك (المريض) يعبر (يخبر) احد ما عن المة بدون اي تحفظات (عندما ليس بالمشفى) أثناء وجوده بالمشفى؟
Tell me about possible things that may influence how people communicate pain in our Jordanian society (hospital). هل لك ان تخبرني عن العوامل\الاشياء التي قد تثر على رغبة المريض بأخبار (التعبير) الآخرين عن المة؟	For example, I have read that women in other cultures such Somali women do not express pain because this is not acceptable in their culture. What it is like in the Jordanian society? انا قرأت في احدى المرات انه للنساء في الصومال ما يبشكن المهن لاي احد لانه هذا الشيء يعتبر عار عندهم في مجتمعهم, هل لك ان تخبرني بما هو الوضع عليه في مجتمعنا الاردني؟ Tell me about the relationship between you and professionals deal with the patient, please. هل لك ان تخبرني عن طبيعة العلاقة التي تكونت بينك و بين الطاقم الطبي\التمريضي الذي يتعامل مع قريبك؟ Does it make difference to deal with a woman/man nurse/doctor? If yes, how? If no, give views. هل تعتقد انه هناك فرق بين تعاملك مع ممرض رجل عن تعاملك مع ممرضة امراة؟
What do you think about the pain management presented to your relative? ما رأيك بالعناية التي قدمت لقريبك للعناية بالالم عنده؟	Do you think there are other things were not done to the patient would help him decrease his/her pain? If yes, like what? هل تعتقد انه هناك اي شيء لم يعمل للمريض, لو عمل له سيخفف من المة ؟ اذا نعم, مثل ماذا؟
To what extent you are satisfied by the nursing care that is presented to you relative to decrease his postoperative pain?	لاي درجة انت راض عن مستوى العناية المقدمة للمريض للتخفيف من المة؟
Is there anything we have not discussed you would like to add?	هل هناك اي شيء تود الحديث عنه اكثر؟ هل هناك شيء لم نناقشه و تود اضافته؟

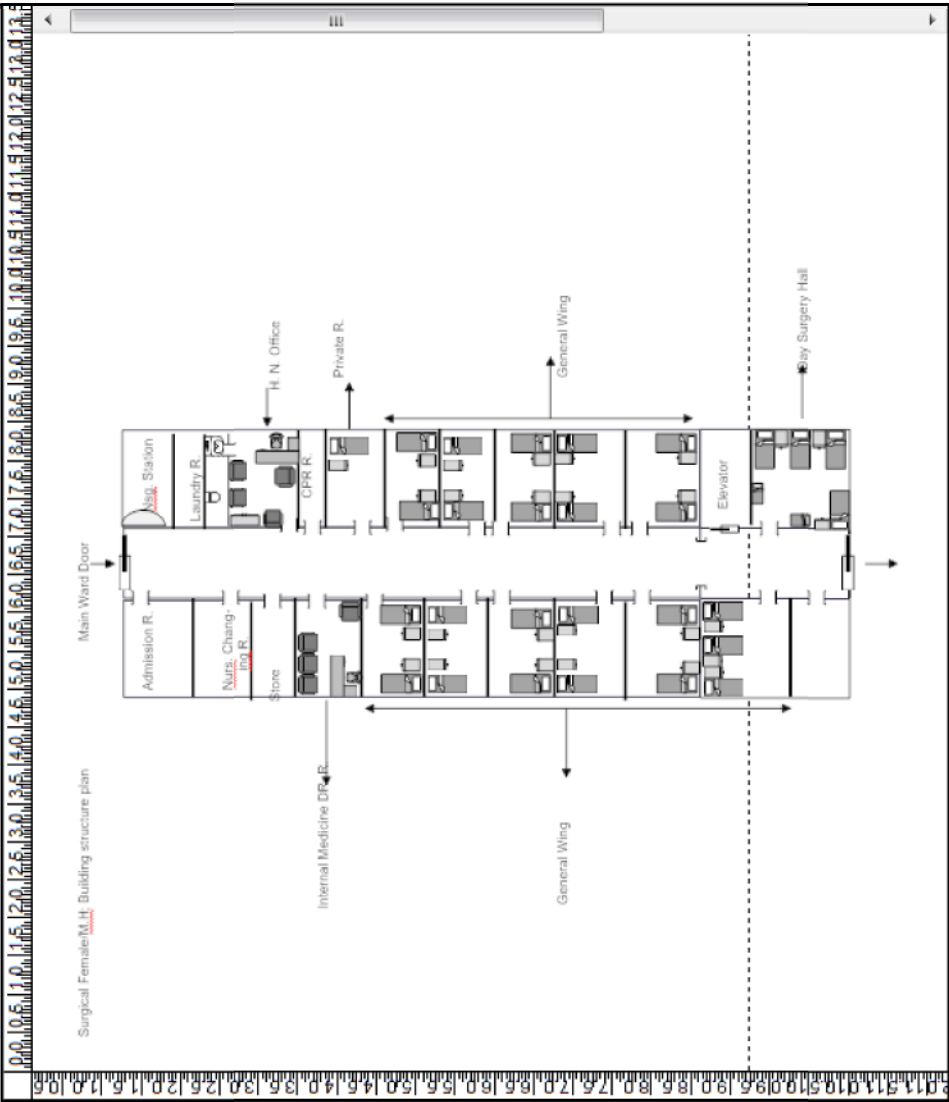
Appendix Nine (A)

Structural Layout: Surgical Male Ward, Hospital (X)



Appendix Nine (B)

Structural Layout: Surgical Female Ward, Hospital (X)



Appendix Ten

Table of newspaper reports about incidents of physical violence against nursing and medial staff retrieved from the electronic archive of two Jordanian official newspapers (March2007-March2010), showing consequences on victims as advertised.

#	Date of publishing report	Newspaper	Number of nurses	Number of doctors
1.	27-4-2007	Alrai ⁴	3 M + 1 M nursing student	
2.	3-6-2007	Alarab Alyawm ⁵	1 M (shoulder dislocation, and broken some other bones)	
3.	6-8-2007	Alrai	1 M (Admitted for medical care)	2 M (Admitted for medical care)
4.	11-11-2007	Alarab Alyawm	3 M (one of nurses had a broken wrist)	
5.	26-12-2007	Alrai	1 M (Admitted to ICU)	
6.	26-2-2008	Alrai		1 (Nasal bleeding)
7.	18-3-2008	Alrai	1 M	1 M
8.	27-3-2008	Alrai	2 M	
9.	30-5-2008	Alrai	2 M	2 M
10.	7-6-2008	Alrai	2 M (One of nurses had a broken vertebral column)	
11.	25-6-2008	Alarab Alyawm	1 M (Admitted to surgical ward)	
12.	26-6-2008	Alrai	2 M (stab wounds by a knife)	
13.	1-7-2008	Alrai		1 (broken arm bones)
14.	3-11-2008	Alrai		1 M

⁴ Alrai (www.alrai.com)

⁵ Alarab Alyawm (www.alarabalyawm.net)

				(traumas)
15.	17-11-2008	Alrai		1 M
16.	21-11-2008	Alrai	1 M (Admitted for medical care)	
17.	31-5-2009	Alrai	1 M	
18.	14-6-2009	Alrai	1 F	1 M
19.	16-6-2009	Alarab Alyawm	1 M (Admitted to hospital for medical care)	
20.	20-7-2009	Alrai		1 M
21.	25-9-2009	Alrai		1 M
22.	28-10-2009	Alrai		1 M
23.	20-10-2009	Alrai		1 M
24.	22-3-2010	Alarab Alyawm	4 M	3 M
Total			27	17