

When the World Health Organization Analgesic Therapies Ladder Fails: The Role of Invasive Analgesic Therapies

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During our professional lifetime as nurses, we will experience patients who will never be forgotten. Sometimes we witness amazing clinical accomplishments and personal growth, and other times we experience disappointments and regrets. Throughout my career, my regrets and disappointments often have been related to being unable to manage patients' intractable, unrelenting cancer pain. I reminisce about what was done and, perhaps, what should have been done to relieve these individuals' suffering. With each new patient and challenge, I, like all nurses, seek to improve my assessment, interventions, and evaluation of my initiatives.

Each nurse, I believe, remembers his or her failures in caring for patients, but within these failures exist opportunities for improvements for the patients who surely will follow. Imagine your patients moaning constantly, facial grimaces becoming their norm. Their families look at the situation with frustration, anxiety, and fear. This, unfortunately, is an all-too-common scenario. We try what often seems to be an arsenal of medications, but comfort seems elusive and really is never achieved. You remember these patients and their families in your dreams, or perhaps I should say nightmares. What could have been done? What did I miss? How can I avoid this ever happening again to another one of my patients or families? These are questions that require immediate answers. Two cases, in particular (but there are many), often come to mind and have affected my clinical practice significantly.

The first case, which occurred early in my career, involved a woman who returned from the operating room following an "open-and-close" abdominal surgery that occurred in the early hours of the morning. She was moaning loudly in pain on arrival to my medical-surgical unit. Because she already received a dose of meperidine prior to arrival, I had no pharmacologic interventions available to administer to promote comfort. I called this patient's surgeon immediately, notifying him of his patient's extreme discomfort. I was instructed quite briskly and without exception to never call him in the middle of the night with an issue related to pain. I intended to inform this lady that her physician felt it was "better" that she does not receive medication at this time. However, on entering her room, I realized that this was not acceptable as I watched this woman clearly suffering. I called the physician back, this time using the patient's telephone, and asked him to explain the need for her to continue in pain. After what seemed like an eternity, the phone at the nurse's station rang and I received

appropriate pain medication orders. This patient and her situation alerted me early in my career about the need for effective patient advocacy.

The second patient was a brilliant, 22-year-old man with end-stage cancer who I cared for throughout his disease process. We shared many laughs and disappointments during his illness. When he died, his parents shared his journal writings with me; I wish I had known his thoughts and fears more clearly during his life. Understanding where our patients are within this experience of cancer is imperative if we are to help them throughout this journey, regardless of where the road may lead. This is an excerpt from his writings.

I went to . . . seeking out hope and healing, physically, mentally, and spiritually. You know, hope is an interesting idea. If you ever had to live on just hope for any extended period of time, you'll understand. I lived off practically nothing but hope for nearly two years: I hope that chemotherapy and radiation will work. I hope that the pain will go away soon. I hope this next MRI [magnetic resonance imaging] shows that my tumor is operable. I hope that I wake up with two legs. I hope I get out of this hospital soon. I hope this depression ends. I hope the next chest CT [computed tomography] is okay. I hope that my cancer will respond as well to chemotherapy as it did the first time. I hope I'm alive in eight months. See, it's not the most productive way to live and it takes a lot of energy. Hope is overrated. So, after I realized this in my subconscious, I kicked hope out of my mind and brought faith back to my soul. At that point, I truly realized that God has a great part to play in each of our lives.

Clearly, we, as nurses, have the opportunity to affect our patients and their families daily within our practice. We are in the unique position to intervene for patients because we spend



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