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1. INTRODUCTION

Pain is one of the most commonly encountered symptoms in patients afflicted with chronic incurable diseases such as advanced cancer and acquired immune deficiency syndrome (AIDS). The world Health Organisation (WHO) has laid down guidelines on the management of chronic pain in adults which all countries must adopted (WHO, 2008). However to be a pro at pain management does not only entail being able to infuse analgesics in the patients' ailing bodies but also examining and dealing with other factors surrounding the pain itself. This essay will discuss the approaches for management of chronic clinical pain for adult palliative patients in Norway and Zambia, drawing up similarities, differences and challenges in both settings as experienced by the author.

Clinical pain is a collective terminology used to describe persistent pain syndromes that offer no biological advantage and cause suffering and distress. Clinical pain can either be acute, transient or chronic, as is the case for palliative patients. Pain can also be described as nociceptive (resulting from damage of structural tissues such as bones, skin, muscle or joint) and neuropathic: due to damage to the nervous system such as peripheral nerves, dorsal root or central nervous system (Paz and Seymour, 2008).

Good pain management is very important as it ensures improved quality of life for the patient's life and a dignified death at the end (Sublett and Heidrich, 2009). Given the economic and cultural differences of the two countries, what can we learn from each in terms of managing pain in adult palliative patients? How do nurses respond to a patient in pain? What factors affect the experience of physical pain?

2. STATEMENT OF THE PROBLEM

In its October 2007 to March 2008 situational analysis on provision of palliative care in Zambia, The Palliative Care Association of Zambia (PCAZ) found that pain was a problem for 85 % of hospice patients (PCAZ, 2008). The International Association for the study of Pain (IASP) defines pain as 'an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage'(Mersky and Boduk, 1994) as cited by Paz and Seymour (2008). In simple words pain is often widely defined as what the person says hurts and occurring when they say it does. Palliative patients often experience moderate or severe physical pain necessitating the use of opiods and other adjuvant treatments. The WHO states that opiod analgesics are readily available in developed nations but are not adequately so in the developing nations. Ironically, the WHO mentions that opiods are essential drugs and quite inexpensive to acquire (WHO, 2008).

3. BRIEF DESCRIPTION

The author had a six weeks placement period in an inpatient cancer unit at a central hospital in Norway. The majority of patients admitted to the unit were elderly and had advanced malignancy. Pain was therefore an expected complaint in most of the patients. There were two teams of nurses working on the unit; namely cancer and palliative unit. In turn each nurse had responsibility of one, two or three patients depending on the staffing levels that particular day. This is referred to as primary nursing. The advantages of this system include the patient having the same nurse, psychosocial needs (which play a very important role in pain experience) are met and there is improved communication between the nurse and the physician as regards to the patient's progress (Pike, 2009). The patient's primary nurse ensured that all the patient's needs were met. Of all the needs that these patients presented with, pain stood out prominently. Patients reacted differently to pain: some barely speaking about it unless asked while others openly talked about it. This to a large extent affected how the nurses reacted to the patient's pain. However the nurses seemed empathetic and would sit down with a patient to listen to their worries. The patient's view about the pain was respected and their wishes taken into consideration. Well after all, as nurses we are taught that a patient is always right!

Basically analgesics and adjuvant treatment were used to relieve pain according to the World Health Organisation guidelines and analgesic ladder (WHO, 2008). The doctors prescribed and the nurses would then administer the medications. Several routes of drug administration, depending on the patient`s condition were employed. Patients would either take the analgesics orally or parenterally. Continuous drug administrative devices such as subcutaneous and intradermal patches were utilised if patients had moderate to severe pain or when swallowing was impossible, regardless of the pain intensity. This ensured excellent pain management for all the patients. Furthermore all the patients under the palliative team had a daily assessment of their well being using the Edmonton Symptom Assessment System (ESAS). This assessment system was very useful in identifying the patient's needs and evaluating the outcome of care being given.

In Zambia however the nursing care delivery system concentrates on duties and it is referred to as functional nursing. This is a very ideal system for low resource environments but one of its disadvantages is that the patient's psychosocial needs are rarely met (Pike, 2009). Furthermore pain management for palliative patients whether in the hospital, hospice or homes is not well structured due to both material and human resource limitation. Currently the country is strained with disease burden therefore; infectious disease management, maternal and child health care are the priorities according to the millennium development goals (Zambia Ministry of health, 2005). However the government is determined to ensure narcotic analgesics are available for pain management in palliative patients, starting with an oral morphine programme (PCAZ, 2008).

All in all, pain management for palliative patients is a great challenge in a poor resource country like Zambia. Regulations that surround opiod administration are strict hence physicians regularly prescribe non opiod analgesics for pain management. Opiod analgesics are mostly used for acute and post operative pain management. In addition continuous drug administration devices such as subcutaneous and intradermal patches are nonexistent, making it difficult for patients who cannot take the drugs orally. In most instances the physicians and nurses have to rely more on the patient's ability to verbally report pain. While psychosocial counsellors visit the chronically ill patients often, they are usually overwhelmed with the huge number of clients that require their services leading to inadequate psychological exploration.

4. ANALYSIS

Pain has only been recognised as a condition that requires treatment and dedicated research during the past 50 years (Paz and Seymour, 2008). To date several theories about pain and treatment modalities have been adopted but there is yet more to be achieved. These are all well meaning efforts aimed at promoting comfort for people experiencing pain. The untold misery that palliative patients suffer due to pain is complex. Therefore it is only humane that measures to relieve this pain exist.

Each patient's pain experience is unique and requires an individualised approach to ensure successful pain management. Aside the internal factors such as pain intensity, and pain threshold, other factors such as cultural background, religious beliefs, and socio-economic factors affect the pain experience. For pain is not only the physical but also the emotional aspects, being influenced by other variables such as anxiety, fatigue, insomnia and feeling of loss of control (Sublett and Heidrich, 2009). For the palliative patient, chronic pain reduces the quality of life and leads to loss of dignity at the time of death. Nurses play a very important role in this regard in that they spend more time with the patient and can do a lot in ensuring that this pain is minimised or totally eliminated.

The World Health Organisation states that being free from pain is every person's human right. However in some countries this ideal is compromised due to resource limitation and also public health policy issues (WHO, 2008).

Given the complexity of persistent clinical pain; sensitivity and team approach on the part of the health care team is required. The team that is managing the patient's pain should have documented evidence about the progress. Furthermore, excellent communication within the health care team is essential for optimal pain management (Sublette and Heidrich, 2009). Ashby and Dowding (2001), as cited by Bostrom et al (2004) state that successful pain management cannot occur in the absence of an honest and open dialogue. Furthermore, studies also show that health care professionals must encourage the patient's thoughts, feelings and methods of handling pain since these all influence pain treatment (Bostrom et al, 2004).

A careful pre-assessment of the pain is vital before attempting any interventions at pain relief. This may include exact location of pain, intensity and nature or character of pain as well as ameliorating and aggravating factors. Various pain assessment tools for instance visual analogy scale (VAS), numeric scales (0-10) and visual descriptor scale have been devised and can be used to measure both physical pain intensity and psychological distress (Sikorski and Barker, 2009). Under no circumstances should the patient's pain be down played because people respond differently to pain and the same level of pain may elicit different responses in each individual. Nurses may hold several myths relating to pain that may affect the way they assess and treat the patient's pain such as;

- Real pain has an identifiable cause
- The same physical stimulus produces the same pain intensity, duration and distress in different people
- Some clients lie about the existence or duration of their pain
- Very young or old people do not have pain
- If a person is asleep, they are not in pain
- If pain is relieved by non pharmaceutical techniques, the pain was not real anyway (Sikorski and Barker, 2009).

Every person's pain experience is individual and nurses must never rely upon their own assumptions to determine how much pain a patient has. The assessment has to be carried out in an unbiased and caring manner and its primary goals are to; identify the cause of pain, understand the client's perception of pain, determine the level of pain that the client is able to continue participating in activities of daily living and to implement pain management techniques. Each assessment should include location, intensity, and duration of pain, as well as disturbance in sleep, appetite, function, concentration and effect on relationships. Pain scales are useful in providing a simple means for the patient and nurse with which to quantify the pain (Sikorski and Barker, 2009).

Both objective and subjective assessment is vital to obtaining a realistic assessment of pain. If the client is not responsive and unable to report pain, the nurse should observe for the behavioural indicators of pain such as agitation, moaning, muscle tension, frowning and rapid heart rate (Sublett and Heidrich, 2009).

Analgesics play a big role in pain management but their use must be according to protocol outlined in the World Health Organisation guidelines on management of chronic pain. The three step ladder involves the progression of pain management using non opiod analgesics and opiods with or without adjuvant drugs based on the patient's pain intensity and response to treatment (Sikorski and Barker, 2009).

Adjuvant medications are drugs that have no primary analgesic action but can serve as analgesics for some painful conditions and are quite effective in the management of pain syndromes that have a neurological component as well as to help in reliving anxiety. They include tricyclic antidepressants, anticonvulsants, corticosteroids and benzodiazepines (Sublette and Heidrich, 2009).

Developing a therapeutic relationship with a patient who is experiencing pain is at the core of successful pain management and may include facilitating the client's expression of feelings about the pain, providing support, reassurance and understanding in order to help the client develop confidence in the nurse and have a sense of being cared for. Pain management strategies including medication are more effective when clients believe that they are in control (Sikorski and Heidrich).

While their duty is not to prescribe drugs, nurses however can play a significant role in ensuring that these drugs are correctly administered, observing for side effects and keeping a record if any, advising the patient about the use of the analgesics, evaluating effectiveness of analgesics and making suggestions for specific changes such as route of administration, interval and formulation (Paz and Seymour, 2008).

Opiods are the mainstay of treatment for moderate to severe pain. Their side effects can be mild and transient while others may be severe and life threatening requiring intervention. Common side effects include but are not limited to the following; constipation due to decreased intestinal motility and reduced gastric emptying, nausea and vomiting due to stimulation of the chemoreceptor zone and rarely respiratory depression (Sublette and Heidrich, 2009).

The route of administration must be carefully selected by the doctor in conjunction with the nurse and the patient. Overall, the oral route is the most preferred because it is cheap, non invasive and its use presents no major complications. However some patients may not tolerate this route due to severe nausea, vomiting, debilitation and

obstruction of anatomical passages hence the need for alternative routes for example; sublingual, rectal, and intramuscular to mention a few.

An around the clock (ACT) schedule is appropriate to ensure therapeutic levels of analgesics at all times for patients with persistent pain and this offers a preventive attitude towards the pain. The goal of ACT dosing is to keep the level of an analgesic in a range high enough to manage pain but low enough for the patient not to experience avoidable or unmanageable side effects. Pain however does not stay at the same intensity throughout the day and additional medications are therefore required to manage break through pain (Sublette and Heidrich, 2009).

Paz and Seymour (2009), outline the following benefits to the patient when a preventive attitude towards pain relief is utilised;

- The patient spends less time in pain
- Doses of analgesics can be lower than if pain is allowed to increase or become severe
- Fewer side effects due to lower doses
- Decreased concerns about obtaining relief when needed
- Overall increase in activities
- Decreased anxiety about returning of pain

For patients with drug resistant neuropathic pain syndromes, local anaesthetic blocks targeted at trigger points in the peripheral nerves, dorsal roots and the sympathetic nervous system have useful but short lived duration. A combinational of both pharmacological and non pharmacological therapies in this instance is often helpful not as a way of completely eliminating the pain but helping the patient cope with the pain (Paz and Seymour, 2008).

As professionals, nurses need to constantly familiarise themselves with current trends through reading in order to dispel long held myths and give quality care to patients. Despite the knowledge that nurses are equipped with during training some studies, for instance Wells et al (2001), have shown that health care professionals can have myths and misconceptions concerning use of opiods such as respiratory depression and fear of addiction. This view is supported by Sikorski and Barker (2009) who further elaborate that the incidence of addiction is actually less than 1%. These fears by health personnel,

although seemingly unfounded, put one in a professional and moral dilemma: the fear of quickening the patient's death as a result of respiratory depression and contributing to abuse of narcotics due to diversion of opiods to elicit use. While encouraging use of opiods for management of chronic clinical pain in palliative patients the undesired results like the ones mentioned above should be borne in mind.

In practice significant respiratory depression is rare during treatment of pain if the opiod dose is increased slowly and reduced when sedation is noted. Some clients actually do develop tolerance to the respiratory depressive side effects of opiods after several days of treatment. It may be noted that a patient who receives an initial dose of an opiod may experience some degree of sedation partly due to the direct effect of the opiod on the brain but also due to the exhaustion the patient experienced from not sleeping well while in pain. Therefore a careful assessment and supervision of the patient coupled with careful titration of the dosage can ensure that opiod side effects are totally avoided or kept to a minimum (Sublett and Heidrich, 2009).

Addiction, also known as psychological dependency, is a pattern of continual craving for opiod drugs when not experiencing pain. There is continued use despite physical, social or financial harm (Sublett and Heidrich, 2009).While research shows that the incidence of addiction when using opiods for pain relief is small it should however still be a concern especially in view of new trends in which patients keep the opiods at home and more and more young people are being treated as palliative patients. Abuse of opiods can lead to untold suffering such as mental illness and social ills in society such as crime.

In spite of medications continuing to serve as a major component of pain management, non pharmaceutical therapies are being increasingly used to provide pain reduction or relief. Non pharmaceutical measures are particularly useful as adjuncts to Pain relief, while the client is waiting for medications to take effect or when the side effects or client concerns make use of medication a problem (Sikorski and Barker, 2009).

To believe that only drugs can offer pain relief is a myth that should be renounced by all. Despite the many drugs available for pain relief, they all have some risk and cost. One danger that might result from the increased awareness and use of drugs in pain management might be the evolution of a new generation of nurses that is wholly

dependent on drugs to treat the patient's pain. As earlier implied pain management must be looked at from all angles in order to treat the patient holistically.

Several non pharmaceutical interventions are available that are non-invasive, low risk, inexpensive, easy to perform and teach. Examples include the following;

- Comfort measures- clean, smooth sheets, soft supportive pillows and a soothing environment
- Cutaneous stimulation- activates the large diameter (A-beta) fibres which stimulate the inhibitory neurons in the spinal cord. This process may be seen as a form of distraction since the client may focus on the pleasant sensation being created than the pain
- Massage is particularly relaxing at bed time and may block pain so as to promote more comfortable sleep, however expert knowledge is required so as not to increase the discomfort in the process
- Heat and cold application have been used by health personnel to manage pain. Extra caution must be taken to avoid burns and frost bites
- Deep breathing reduces muscle tension and anxiety
- Rhythmic breathing may provide pain relief by stimulation of the baroreceptors in the atria and carotid sinuses. It also offers both relaxation and distraction
- Music causes people to relax through release of endogenous opiods and disassociation
- Guided imagery helps to visualise a pleasant experience. Imagery works in several ways by helping people distract themselves from the pain which may increase the pain tolerance as well as enhancing relaxation

These measures have additional benefits of promoting comfort, increasing mobility, altering physiological responses and perception of pain; reducing fear and giving patients a sense of control over their pain. The physiological changes that are thought to be brought about by these therapies include decreased muscle tension, dilatation of blood vessels, strengthening of immune system and release of brain chemicals such serotonin that are themselves natural pain killers (Sikorski and Barker, 2009). Non pharmaceutical interventions also improve the nurse patient relationship ensuring more openness and better understanding of the patient's symptoms as the nurse spends more time with the patient.

5. CONCLUSION AND RECOMENDATIONS

Pain is a very individual and complex phenomenal which has special implications for palliative patients. Massive volumes of work have been done on this very important subject whose complete understanding still eludes us. Although it may not be possible to always offer 100% pain relief in palliative patients, some relief of pain is cause for celebration knowing that we are promoting the quality of life, affirming life and ensuring a dignified death. Overall the Norwegian health system is well equipped with pain management strategies including readily available opiods, drug administration devices and specialised human resource. However from the hospital perspective, it appears there is too much dependency on drugs to treat pain in palliative patients. There is need to include more of the non pharmacological therapies in the pain relief package. The following are the recommendations for improvement of practice in Zambia;

- A variety of opiod formulations such as suppositories and intradermal patches should be made available for patients unable to take drugs orally.
- Patients should be more involved in the management of their pain; they should be allowed to have a say in both the assessment and treatment of their pain
- Pain assessment scales should be introduced so as to help measure pain intensity, as said by the patient.
- Standardised pain treatment protocols should be formulated to serve as guidelines for the health care team.
- Despite the challenges of high workload, nurses should strive to have a one on one therapeutic relationship with the patient as this would help patients to be more open with reporting pain and requesting for analgesics.

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