Use evidence-based practice to make your argument

Ann J. Brady, RN, BSN

GETTY IMAGES

Make the case for better pain management without undermining the care team.

THE CHALLENGE

"I've been doing this for 30 years." I raised my eyebrows at the way the attending physician said this, sure by his tone that he had a point he wanted us all to hear. "The last thing we want is for you to get too much morphine and end up with breathing problems." I held my tongue, waiting to see if he had more to say, waiting for the palliative care doctor to respond. We were in the middle of a family meeting when he made his declaration, a clear line in the sand. The patient, a 67-year-old woman with metastatic breast cancer, closed her eyes as he spoke. She was new to our team but her cancer was not new to her. Pain was not new to her either, but the worsening level of it was. The problem was her medical oncologist was in a city more than an hour away. She'd gone to him when she was first diagnosed, but her breast cancer had spread and the trip back and forth to his clinic was too difficult. Now, near the end of her cancer journey, she had to rely on the house staff at the hospital close to where she lived. She had to rely on a doctor with 30 years of experience but no knowledge of her. And he was someone who did not seem to be completely up-to-date on pain management for patients with advanced cancer. With bony lesions and liver involvement, she needed the pain meds she was on; in fact, she needed more of them.

"Well," the palliative care doctor paused. The other doctor was a formidable opponent. He had three residents in tow, so there was an additional burden on the palliative care team: make the case for better pain management without undermining this doctor in front of the residents. "Well," he repeated, "she has done pretty well on her current pain regimen until recently. She hasn't had any respiratory problems. Sure, breathing is always a concern, but she is nice and alert."

"Morphine is not something to be taken lightly." Clearly the teaching doctor considered this a teachable moment as he nodded to each of his residents. I saw the exchange of self-satisfied nods. He wasn't going to be easily converted.

Surprisingly, we reached a compromise rather quickly. More morphine was acceptable to him as long as she had additional monitoring. The patient and family didn't seem to know about the undercurrent of tension. Both the attending doctor and the palliative care doctor had enough experience to handle their conflicting views without

overt disagreement. But I left the room muttering to myself. What I wanted to say was, "I have 25 years of experience working with hundreds of doctors. We nurses spend more time with patients in pain than you guys ever do." I was upset that I hadn't spoken up. Then I remembered something I had learned at a conference: use evidence-based practice to make your argument.

THE SOLUTION

I'd like to say I immediately ran back to my office and pulled up articles to back up the use of morphine. But although the physician was adamant in his conviction that morphine was dangerous, he had kept her on it. I stewed about the whole conversation, remembering the smug look on the faces of the residents. Yet, more than that, I worried that the bedside nurse who had heard his proclamation would be overly cautious in the use of breakthrough morphine, that at a time when this patient needed good pain control, the nurses would be afraid of overmedicating her. I worried that her family, already concerned because she was not doing well, would discourage her from asking for pain medications. My motivation for clarifying the use of morphine had to be for the good of the patient, not for my desire to prove myself to the doctors. I pulled up an article on the use of morphine in advanced cancer, and I copied pages from Pasero and McCaffery's book on pain management, *Pain Assessment and Pharmacologic Management*.[1] I made two copies of each, highlighting the part where it says that since 1986 the World Health Organization (WHO) has considered morphine to be the "gold standard" in pain management for advanced cancer. I took the copies to the nurse caring for her and showed him the evidence. He thanked me for the information and said he would keep her comfortable. I spent some time with the patient and family reviewing her pain level and realized they were at ease with her taking morphine and that if she needed more they would encourage her to ask. I tucked one copy of my "evidence" into the inside pocket of the chart; hopefully the doctors would see it. I put the other copy inside the clipboard I always carry with me. Having a copy of the article and the copy of pages from the book was empowering, but those articles didn't convince me of the safety of using morphine in this situation; instead they reminded me of what I already knew.

This happened several weeks ago. The patient went home on hospice. The residents have moved on to a new rotation. But I am still mentally stuck back in that family meeting, waiting for someone else to say what I already knew. I can excuse my silence by reminding myself that the last thing the patient or family needed was to see conflict. And that is true. But I stepped into the hallway and in silence watched the attending walk down the hall with his entourage. I hesitated then, and I kick myself for it now.

It is called a teachable moment because the opportunity occupies a moment in time. Getting the information to the nurse after the fact was a way of teaching, just as leaving the articles in the chart was. But next time I want to do things differently. I could unravel this communication challenge by validating what the attending said. After all, he is right: morphine is not to be taken lightly. Then I could add the information I know to be true: the evidence. ■

It is called a teachable moment because the opportunity occupies a moment in time.

Discussion questions

1. How might you have handled this situation? What strategies have you found useful, and which have backfired?
2. Have you used evidence to support your practice? What kind of response did you have?

Ann Brady is the symptom management care coordinator at the Cancer Center, Huntington Hospital, Pasadena, California.

REFERENCE

1. Pasero C, McCaffery M. *Pain Assessment and Pharmacologic Management*. St. Louis, MO: Mosby Elsevier; 2010.