

Symptom Management: What We Know and What We Do

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Nursing has considered symptoms as perceptions, experiences which are often distressing, as opposed to the medical perspective which views symptoms as keys to diagnosis. Diminishing distressing symptoms has been at the essence of nursing since its inception. In her book *Notes on Nursing: What It Is and What It Is Not*, Florence Nightingale highlights the relief of pain and discomfort as central to nursing (Nightingale, 1946). Much knowledge has been acquired about certain distressing symptoms, particularly pain, but less about others. The mechanisms of pain, factors that exacerbate it, pharmacological agents that decrease it, and comfort measures that soothe it have all been studied by different disciplines, including nursing. There are even textbooks on the nursing management of pain where this information is detailed (Donovan & Watt-Watson, 1992).

However, there are still data suggesting that nurses do not utilize the knowledge they have regarding pain management (Abbott et al., 1992; Donovan, Dillon, & McGuire, 1987), particularly in children (Johnston, Abbott, Gray-Donald, & Jeans, 1992; Schecter, Allen, & Hanson, 1986). This is due, in part, to inconsistent knowledge and inconsistent beliefs about the value of changing practice among nurses. Howell, Foster, Hester, Vojir, and Miller (1996) describe the implementation of a pain management program for nurses in a pediatric setting. They clearly describe the process of the acquisition of knowledge by staff. From this description, the comprehensiveness involved in changing staff attitudes towards pain management is evident and can partly explain why less comprehensive and less rigorously implemented programs have failed. These authors followed through with their program and found that ultimately nurses truly "owned" components of the program's pain assessment and management strategies, as shown by their personal modifications which maintained the principles of the program.

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Another reason why nurses do not appear to manage pain adequately in spite of what is known about pain is, in fact, that there is such an abundance of knowledge that it is difficult to make decisions about which particular strategies to use in specific situations. Carroll (1996) discusses evidence-based practice in the area of pain management. She makes a strong case for the use of meta-analysis in the area of pain management, based on its strengths and the weaknesses of other approaches to synthesizing current knowledge. A caveat on the use of meta-analysis is that it can only be as strong as original articles are scientifically sound. Given the abundance of literature on pain management, this is less of a problem for that particular symptom.

While we do know a lot about physical pain, and while light is being shed on how we can use that knowledge in practice, the area of psychic pain is much less understood. Observation and documentation of symptoms of schizophrenia have been "medicalized," the goal being accurate diagnosis. Baker (1996), however, used qualitative methods to examine the subjective experience of patients suffering from schizophrenia and found that psychic pain was the overriding symptom, or distressing element of their experience. Furthermore, the fluctuating intensity of their psychic pain, as opposed to other symptoms, was a key signal of changes in their illness trajectory. The reports she was able to elicit from her participants of their emotional pain were moving and poignant. Baker puts these reports into a framework that can be used by nurses, taking the reports beyond a beginning appreciation of what their experience is like.

The major concerns of nursing, to both sift out what we really know about the symptom and use that knowledge in managing the symptom, apply to all symptoms.

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