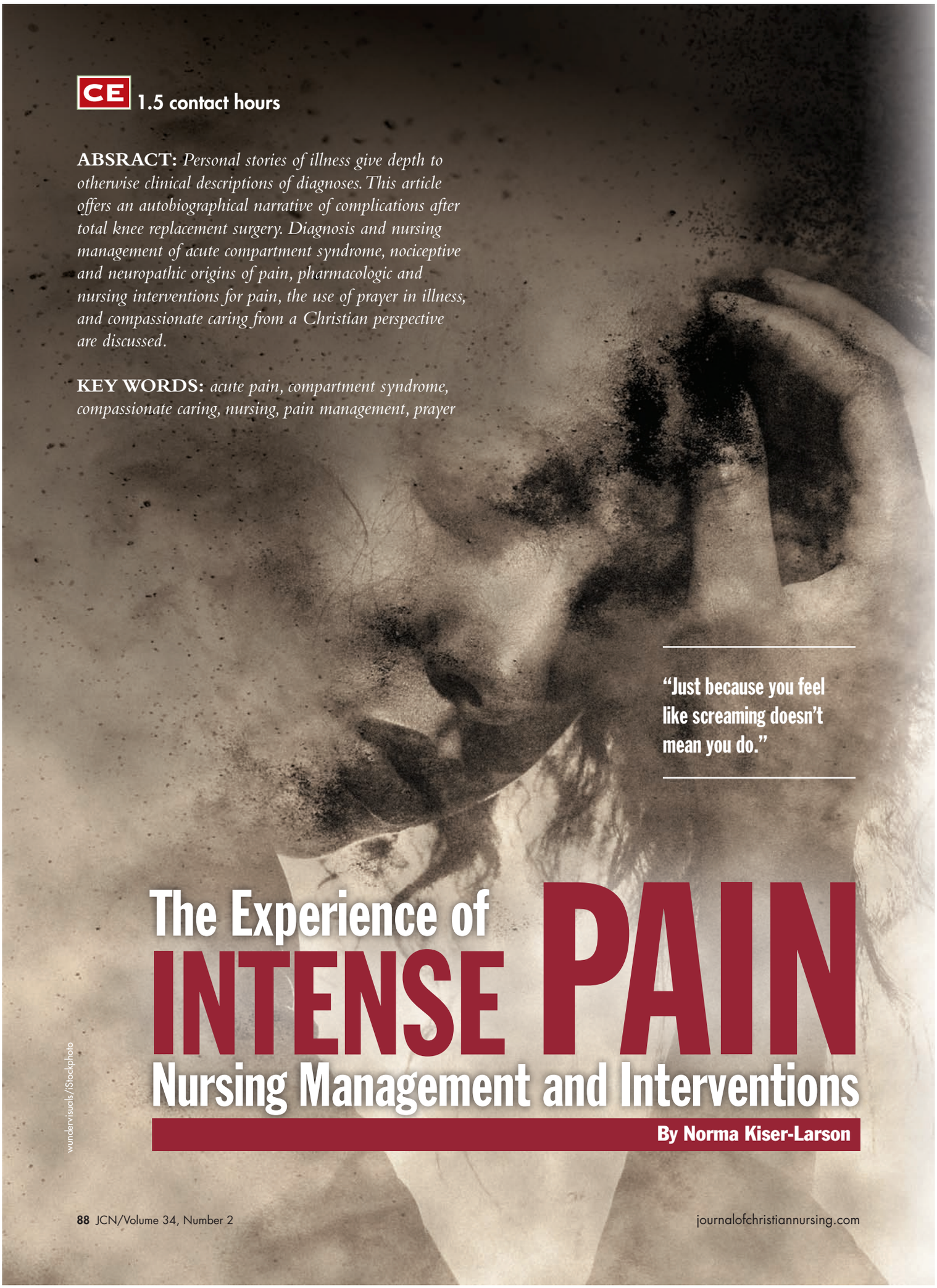
CE 1.5 contact hours

ABSRACT: *Personal stories of illness give depth to otherwise clinical descriptions of diagnoses. This article offers an autobiographical narrative of complications after total knee replacement surgery. Diagnosis and nursing management of acute compartment syndrome, nociceptive and neuropathic origins of pain, pharmacologic and nursing interventions for pain, the use of prayer in illness, and compassionate caring from a Christian perspective are discussed.*

KEY WORDS: *acute pain, compartment syndrome, compassionate caring, nursing, pain management, prayer*



"Just because you feel like screaming doesn't mean you do."

The Experience of INTENSE PAIN

Nursing Management and Interventions

By Norma Kiser-Larson

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Although we as healthcare providers can explain pain from physical, psychological, emotional, and even spiritual perspectives, there remains a component to pain that borders on incomprehensibility. As a nurse, I have often asked patients to describe their pain and quantify it using a scale of "0" or "1 to 10," with 0 or 1 being no pain, and 10 the worst pain possible. Lower levels of pain are harder to quantify, but intense pain is easily identified as *10!* My experience of intense pain was related to an uncommon complication following bilateral total knee replacement (TKR) surgery. Acute compartment syndrome in the lower right leg was diagnosed 2 days postsurgery on Thanksgiving Day.

INCOMPREHENSIBLE PAIN

Late afternoon of the day following surgery, I felt the acute pain of both TKR postsurgical pain and a pain of unknown origin in the exterior of my right lower leg. A nerve block lasting approximately 24 hours had been initiated in the operating room, thus the delay of severe pain. The pain intensified within the following 24 hours, especially when my legs were placed in the passive range-of-motion apparatus. It seemed odd to me that only my right lower leg was sensitive and painful, whereas the pain in both knees felt approximately equal.

Norma Kiser-Larson, PhD, RN, is an associate professor of nursing at North Dakota State University, Fargo, North Dakota. She is a member of First Assembly of God Church, Fargo, North Dakota. She is actively involved in prayer ministry, jail/prison ministry, and missions.

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During the night and the following day, I made known that I was experiencing more and more pain in my right leg. Early afternoon, the on-call physician and a medical student examined my knees and lower legs, making a comparison of both extremities.

"Prayer is probably the most common intervention for illness outside of physical medicine."

"What do you think it is?" the physician asked of the medical student.

After a moment, the student replied, "I think it's compartment syndrome."

The physician's responded, "I think you're right." He mentioned how someone in my situation normally screams in pain.

I said, "Just because you feel like screaming doesn't mean you do." I was definitely *feeling* a significant amount of pain.

I underwent an emergency fasciotomy to relieve dangerous pressure within the lower leg compartment. The incision extended from just below my knee to my ankle, while the open gaping wound was over 10 inches in length. Before and after, I prayed with confidence, knowing God was with me. Although in excruciating pain, I had no sense of fear or panic.

Although narcotic analgesics helped, pain in my lower leg and foot remained substantial. At times it felt like a lightning bolt hit my lower leg and foot, and my whole leg would jerk. At other times, it felt like my foot was being stabbed. Prayer, along with a sense of peace and confidence that the pain would improve, were uppermost in my mind.

After the fasciotomy and return to the orthopedic unit, I expected to be on the road to recovery, but that was not the case. Two additional surgeries were required to remove nonviable tissue. Four surgeries, each with general anesthesia, were needed within 2 weeks. The pain in my right lower leg and foot intensified after each of the last two surgeries. To decrease the chances of infection, and hopefully speed healing, a negative pressure wound therapy system (wound VAC) was applied to the large open wound.

One of the most intense times of pain was the first wound VAC dressing change. It was all I could do to just keep breathing. By God's grace, pastors from my church happened to be visiting, and I asked the nursing staff if they could stay. Both pastors prayed during this unbearable time, when I couldn't. Many times since that day, I have thanked God for sending not one, but two pastors, just when I needed them most.

I gained significant understanding during this time of how neuropathic pain differs from other types of pain. The pain varied between searing, throbbing, burning, or as if bolts of electrical current were piercing my

foot and leg. Daytime offered distractions; night was the worst. I have always opted for a minimal amount of medication, and especially pain medication. But many times I asked if it were time for pain medication. Slight movement intensified my agony.

ORIGINS OF PAIN

Pain can be described in concrete ways. 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" (IASP, 2014a). Pain includes both the awareness of an uncomfortable stimulus and responses to the experience.

Neuropathic pain is a complex pain syndrome caused by a variety of problems with nerves or the processing of nerve impulses.

Pain can be delineated according to types or classifications: *nociceptive pain* or *neuropathic pain*. *Nociceptive pain* is caused by direct assault on tissue. It is nonneuronal but results from activity in neural pathways secondary to actual tissue damage or potentially tissue-damaging stimuli. Subsets of *nociceptive pain* include *somatic and visceral*. *Somatic pain* is typically localized and usually stems from muscle, joint, bone, skin, or connective tissue. *Visceral pain* is caused from damage to a body organ, with localized pain occurring from some obstruction, usually resulting in poorly localized pain (IASP, 2014b; Warren, 2010)

Neuropathic pain is a complex pain syndrome caused by a variety of problems with nerves or the processing of nerve impulses. Specifically, it is "pain caused by a lesion or disease of the somatosensory nervous system" that allows us to feel touch, pressure, pain, temperature, position, movement, and vibration in our body (IASP, 2014c). A *lesion* is an identifiable abnormality on a nerve, often from known trauma; *disease* is when the cause of the lesion is from a known disease, like diabetes mellitus or vasculitis. Neuropathic pain can occur with a gradual onset, as with diabetic or idiopathic neuropathy, or have an acute onset related to injury or insult (i.e., postherpetic), surgery, or certain types of cancer and chemotherapy (D'Arcy, 2014; Sadler, Wilson, & Colvin, 2013).

Subsets include *central neuropathic pain* and *peripheral neuropathic pain,* depending on whether damage has occurred to central or peripheral nerve tissue. Pain may be felt in the area of damage and/or in the distribution of the damaged nerves, even when a part of the body has been removed (as in the case of phantom pain after a foot is amputated).

Diagnosis of neuropathic pain can be challenging, thus knowing the patient's history and making a careful assessment of pain are especially important. An accurate diagnosis of acute-onset neuropathic pain is critical, in order to offer *appropriate* treatment. Patients with neuropathic pain may respond poorly to traditional opioid medications and have poor pain control. If not treated, acute neuropathic pain can progress to chronic neuropathic pain (D'Arcy, 2014; Sadler et al., 2013).

Pain also is labeled as acute or chronic. *Acute pain* occurs suddenly and is accompanied by physical manifestations, such as increased pulse, sweating, elevated blood pressure, hyperventilation, or pupillary dilation (Chou et al., 2016). *Chronic pain* may be neuropathic or nociceptive and extends beyond the expected or usual time for healing. Chronic neuropathic pain serves no protective function, is unrelated to nociceptive or tissue damage, and serves no useful purpose (Fornasari, 2012).

NURSING INTERVENTIONS FOR PAIN

A preface to all pain management interventions is that patients should be carefully assessed and monitored for pain, adequacy of pain relief, and adverse side effects. Validated pain assessment scales (Numeric Rating Scale, Verbal Rating Scale, Visual Analogue Scales, Pain Thermometer, Faces Rating Scale) should be used prior to and after pain interventions. In addition, pain assessment should include history, location, onset and pattern, pain quality (what it feels like), relieving and/or aggravating factors, prior treatments, impact of pain, and any barriers to assessment such as culture, language, cognitive status, and so on (Chou et al., 2016).

Acute pain from injury or postoperatively typically is managed by administering analgesics as prescribed. Multimodal analgesic administration should include acetaminophen and nonsteroidal anti-inflammatory agents unless contraindicated, along with opioids as needed (Chou et al., 2016). First-line pharmacologic management of chronic neuropathic pain includes serotonin norepinephrine reuptake inhibitors (SNRIs) (duloxetine, venlafaxine) and tricyclic antidepressants (TCAs) (nortriptyline, amitriptyline), which affect neurotransmitter reuptake; and gabapentin and pregabalin that inhibit neurotransmitter release and decrease neuron hyperexcitability. A second-line treatment is topical anesthetics like 5% lidocaine patches and 8% capsaicin high-concentration patches to offer localized pain relief, and use of opioids like tramadol and oxycodone (Attal & Bouhassira, 2015; D'Arcy, 2014).

In addition to pharmacologic agents, commonly utilized nursing interventions for pain reduction include patient education, massage, guided imagery, relaxation, and music. The interventions can vary on a continuum, from orders for a specialist to conduct treatments, to nursing interventions, to unofficial use of the concepts by the patient. Cognitive-behavioral interventions do not have strong-quality evidence support; however, most do not harm the patient, and anecdotal reports suggest positive patient outcomes. One caveat is these interventions are limited in helping children with pain (Chou et al., 2016).

Patient education can be critical in reducing anxiety, improving patient coping, and managing pain. Keeping patients informed and involving them in decision-making can decrease stress (Chou et al., 2016). The nurse should teach the patient and family, before and after surgery, what to expect so there are as few surprises as possible. Talk to them about pain interventions and ask what typically helps the patient manage pain. When possible, before surgery or when not in acute pain, help the patient practice relaxation techniques, such as deep breathing, focused muscle relaxation, and visual imagery. Assist the patient and family in understanding all activities, equipment, medications, and interventions.

It is important to assess for understanding, using the teach-back method, where the patient and family repeat information back to you. Research has shown that verbally repeating teaching information back to the provider reveals misunderstandings, gaps or missed information, and strengthens knowledge (Agency for Healthcare Research and Quality, 2015). Remember that when patients are in pain, information should be kept short and focused.

Massage therapy is a popular nonpharmacologic treatment. Cherkin et al. (2011) studied 401 participants with low back pain, using relaxation massage (136), structural massage (132), or a control group with usual care (133) for patients with back pain. Both massage therapy interventions were shown to be effective treatments for chronic low back pain, with benefits lasting for a minimum of 6 months. Even brief massage offers the nurse or nursing assistant opportunity to interact with, teach, and support the patient.

Relaxation exercises, using focused breathing and muscle contraction and relaxation, can decrease anxiety and pain. Total body relaxation is one commonly used intervention. Four groups were studied in a randomized control trial of 118 orthopedic patients having total hip or total knee surgery (Seers, Crichton, Tutton, Smith, & Saunders, 2008).

Nursing assessment and reporting is critical for early diagnosis and treatment of Acute Compartment Syndrome….Delayed diagnosis can lead to tissue necrosis, renal failure, extremity amputation, and death.

Compartment Syndrome: What Do I Look For?

The muscles, nerves, and blood vessels in the extremities are held in place in compartments covered by a tough membrane, the fascia. *Compartment syndrome* is the process of increased tissue pressure and progressive development of compression within the confined space of a compartment. Pressure initially reduces capillary flow, causing ischemia, then a vicious ischemia-edema cycle initiates, as the capillaries dilate to increase blood supply and plasma proteins and fluid leak out, resulting in more edema. The result is tissue damage with excruciating pain (Harvey et al., 2012).

Compartment syndrome can be *chronic exertional compartment syndrome* related to exercise, or *acute compartment syndrome* (ACS) following trauma, burns, postsurgical procedures, fractures, prolonged limb compression, and infection (Harris & Smith, 2013; Harvey et al., 2012). Compartment syndrome can occur anywhere in the body but is most common in the extremities, especially the lower legs (Alexandrescu & Van Espen, 2014). Causes are classified as a decrease in compartment size, an increase in compartment content, or pressure applied externally (Copstead & Banasik, 2013). Improper or delayed diagnosis of ACS has been cited as one of the most common causes of orthopedic malpractice lawsuits (Harvey et al.).

Nursing assessment and reporting is critical for early diagnosis and treatment of ACS. Pressure needs to be relieved from external (cast or pressure dressing), or internal (edema, fluids) as soon as possible. A fasciotomy (opening the fascia) most likely is needed. Delayed diagnosis can lead to tissue necrosis, renal failure, extremity amputation, and death. Permanent damage can occur in 4 hours (Cometa, Esch, & Boezaart, 2011; Harris & Smith, 2013), with some estimates at 6–8 (Harvey et al., 2012) and 12 hours (Garner, Taylor, Gausden, & Lyden, 2014). The greater the tissue damage, the greater the pain, risk of infection, permanence of disability, disfiguration, and treatment cost.

Peripheral pulses and capillary refill can be normal in ACS, so what should you look for to assess for developing ACS? A first sign is abnormally intense, constant pain that is not relieved as expected by analgesics and is exacerbated by movement. Another early sign is paresthesia (Garner et al., 2014). When you suspect a problem, monitor at least every 2 hours for pain, edema, unusual tenderness, skin color, peripheral pulse, paresthesia, and muscle weakness—and report findings immediately. Assess for pallor and capillary refill time (CRT) in the extremity and report

CRT longer than 2 seconds and compare to the other extremity. If you have difficulty palpating a pulse, use Doppler ultrasound measurement (Harris & Smith, 2013).

Numbness and tingling from nerve compression or ischemia can be assessed by asking the patient to close their eyes and tell you when they feel you stroking the affected area with a wisp of cotton. Also touch the skin lightly with your finger and ask the patient to open their eyes and show you where you touched him or her. Late signs of ACS are decreased muscle strength, paralysis, and pulselessness (Harris & Smith, 2013; Garner et al., 2014).

The orthopedic surgeon may check for elevated intracompartmental pressure, using an 18-gauge bevel needle manometer transducer system that measures tissue pressure resistance to injected saline. However, signs and symptoms offer the best indication of ASC. Diagnosis can be delayed if the patient has a nontraditional etiology, has had regional anesthesia (nerve block), or is confused or overly sedated (poor mental status) (Garner et al., 2014).

If a patient is exhibiting ACS symptoms, in addition to assessing and reporting findings, place the extremity at heart level. Elevation can reduce arterial blood flow, while lowering the extremity can increase edema and compartmental pressure. Monitor for hypotension, which can decrease tissue perfusion, and administer pain medication and oxygen as ordered. The patient's provider may order removal of dressings or anything that might be pressing on the extremity, and make the patient NPO in anticipation of surgery. Expert patient teaching, holistic support, and facilitating informed consent for treatment is critical (Garner et al., 2014; Harris & Smith, 2013).

Once a definitive diagnosis of ACS is made, a majority of patients will undergo emergency fasciotomy. Removal of necrotic tissue may be required both emergently and after the fasciotomy, as well as later skin grafting. Opening ischemic tissue places the patient at high risk of infection, and vigilant wound care will be required. However, good nursing assessment and reporting will lead to earlier diagnosis, intervention, and help minimize tissue damage.

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Two were relaxation intervention groups, one total body relaxation, and one jaw relaxation only. Two control groups were given usual care, with the attention control group asked to describe what they did, felt, and thought when in pain, and the other control group had the usual care. The authors concluded there was no evidence that the relaxation efforts were effective for even an hour after the intervention for total hip and total knee surgical patients. However, relaxation therapy may be effective for different types of pain. Positive guided imagery can assist in helping patients with less severe pain to relax (Chou et al., 2016).

Music is thought to serve as a distractor, help people go to a mentally relaxing place, and release endorphins and reduce catecholamine levels (Ozer, Karaman Ozlu, Arslan, & Gunes, 2013). Comeaux and Steele-Moses (2013) studied the effect of music on state anxiety (anxiety at the moment, as opposed to trait anxiety), pain management satisfaction, and environmental noise satisfaction in postoperative patients receiving prescribed analgesia. Findings indicated a significant difference between the control (no music) and intervention (30 minutes of nonlyrical preprogrammed music) groups regarding pain management satisfaction and environmental noise satisfaction, with those in the intervention group having higher pain management satisfaction and environmental noise satisfaction. However, the difference between the groups was not significant, related to state anxiety. Ozer et al. (2013) found that pain in postoperative open-heart surgery patients was significantly reduced ($p = .001$) by listening to 30 minutes of music of their choice, and blood oxygen saturation significantly increased ($p = .001$) over a control group that did not listen to music.

Some alternative interventions are not options for total knee surgery patients or for compartment syndrome. Although I did not have the option of massage therapy for my leg, one certified nursing assistant (CNA) offered back rubs, which were a welcome relief. Music type is personal. I listened to music at night, when it was difficult to sleep. As a nurse, I have taught various types of relaxation techniques and have made recordings of muscle relaxation techniques. I applied these relaxation techniques when I felt my muscles becoming tense. Although relaxation was a welcome tension reliever, it didn't appreciably decrease my leg and foot pain. One intervention I used that is not discussed in literature for pain management is prayer.

THE POWER OF PRAYER

Prayer has not specifically been studied as a pain intervention, but prayer made all the difference in the world for me in times of great pain. Although not researched as a pain intervention, many articles have been written about prayer and the power of prayer. Oliver, an Australian physician who studied prayer in 999 cancer patients, writes, "Prayer is probably the most common intervention for illness outside of physical medicine" (2013, p. 95). His triple-blinded study found a statistically significant increase in peace, faith, and emotional and functional well-being at 6 months in the experimental group (those prayed for) over the control group (not prayed for). A number of studies have been inconclusive as to whether prayer for healing is effective (Krucoff & Crater, 2009; Narayanasamy & Narayanasamy, 2008), including a Cochrane systematic review (Roberts, Ahmed, Hall, & Davison, 2009).

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Patient education can be critical in reducing anxiety, improving patient coping, and managing pain.

Two studies often referenced as showing no beneficial effects are the two clinical trials of prayer for patients experiencing heart disease (known as the MANTRA II study) and the Study of Therapeutic Effects of Intercessory Prayer (commonly called the STEP study), where prayer was undertaken for patients after heart surgery (Fung & Fung, 2009; Krucoff & Crater, 2009). However, an important factor is that prayer cannot be controlled. Patients in "non-prayer groups" have people praying for them. Knowledge of prayer was not part of the protocol in the MANTRA I and II studies. Yet nearly half the patients were aware that people were praying for them, and nearly 90% of participants in elective settings knew there was prayer on their behalf (Krucoff & Crater). Oliver (2013) attempted to control for this in his Australian study, where neither researchers, those praying, or patients knew who was being prayed for through special remote intercessory prayer.

Koenig and associates at Duke University have published numerous articles on prayer and religiosity in general, and specifically with cardiac patients. In one study, they identified four categories of people, based on attending religious services, prayer, positive coping, and day-to-day spiritual experiences. The categories were: highly religious, moderately religious, somewhat religious, and nonreligious. The highly religious scored high in all areas of health and well-being (Park et al., 2013).

Narayanasamy and Narayanasamy (2008) contend that a benefit for all who attempt to pray is that it creates a relationship with God, and the more an individual prays, the more the relationship is developed. They identified four types of prayer: transaction, petition, submission, and intercession. Prayer of transaction is talking to God in a personal way, drawing the petitioner closer to God, which can be transformational in deepening one's love for God and developing new insights on granting and receiving. Prayer of petition is making a request of God. This is often asking God to intervene and heal the person making the petition. The third type is prayer of submission, which is giving something over to God. Control is relinquished to God instead of self. The last type is intercessory prayer, going outside of one's self and petitioning God on behalf of another. Intercessory prayer can transcend time and space. Some remarkable answers to prayer have been attributed to intercessory prayer (Brown, 2012; Narayanasamy & Narayanasamy; Oliver, 2013).

Some literature denies prayer has any beneficial effect or at least benefits based on reality. Sharp (2010) argues

Questions About Prayer

By Norma Kiser-Larson

What is prayer,
And how do we know it works?
Is it just a fuzzy feeling
That gives temporary relief to our anguish?
Is it an opiate,
That deadens our desires?

I want to measure prayer.
Could I use a ruler or a yard stick?
Perhaps I could pour my prayers in a container.
Would a pint, a quart or a gallon suffice?
I could count the words I say,
Or the minutes I pray.

What composes prayer?
Is it like wishing on a star?
Is prayer just a lucky charm,
Or is it the saying of just the right words?
Maybe prayer is a mix of desire and hope.
Prayer IS desire and hope and SO much more.

Prayer is confidence in almighty God who gave his only Son
That we can have communion and sweet fellowship with Him.
It is knowing that He will bring us from where we are
Into a new day where we can see more clearly.
Through prayer we can know Him intimately.
And experience His wonderful love and peace that passes all understanding.

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that many using prayer are able to manage negative emotions through "interactions with imagined others" (p. 418). Smilansky (2012) believes that a problem exists with the morality of some prayers in which a benefit for one or more people could, at the same time, have negative consequences for others (i.e., "God, let me get the job!" means someone else does not). He poses three scenarios in which, if the prayer (as he has stated it) is granted, it will mean disaster for one or more people. One scenario portrays a man caught in an avalanche; if the avalanche turns at a nearby junction, it would save him but devastate a small village. The problem with Smilansky's argument is that people are not locked into an *either or* situation in prayer. The man could ask God to work and save both him and the village.

Some profound examples of prayer in the literature come from first person accounts (i.e., Shelly, 2005; Cottle, 2010; Strang, 2011; Brown, 2012; Aitken, 2013; Oliver, 2013). The most frequently expressed prayers in reviewed literature were petition and intercessory, followed by transaction, and submission. Experiences range from supernatural physical healing, remarkable or speedy recovery, decreased anxiety, increased well-being, and decreased spiritual distress, to an encounter with God and choosing to pursue a relationship with God. Several authors point out that it is likely that prayer is beyond the scope of research to assess or measure an impact in healthcare. Shelly concluded, that, "ultimately, healing is receiving physical, mental, emotional and spiritual wholeness from God" (2005, p. 14).

I found that prayer brought a sense of God's presence and support in times of severe pain. The coming of the pastors at my first wound VAC dressing change was, for me, supernatural. I did not get an infection, though I was a high risk. The sleepless nights of crying out to God changed me. The knowledge that many family members and friends were praying for me gave me courage. As I contemplated what I found in the literature, along with my own pain narrative, I penned the prose, *Questions About Prayer* (Sidebar). Prayer most definitely made a difference in my arduous journey of recovery. Prayer literature suggests that this is true for many patients (Kim-Godwin, 2013).

COMPASSIONATE CARING

When a person is sick or experiences times of pain, compassionate caring is desperately needed. Nurses and patients alike speak of caring as an ideal nursing characteristic. Wysong and Driver (2009) identified "Caring Practices" as patients' ideal nursing skill, with a list of caring attributes composing the competency. Attributes included: compassionate caring, gentle and kind concern, giving patients reasons to feel comfortable with being in the hospital, bonding with the patient, interest in the patient as a person, good eye contact, using the patient's name, use of humor, attentive listening, being intuitive, friendly and

cheerful, and prompt to complete items needing follow-up, as well as having a positive work attitude. An essential part of caring, according to cancer patients, was "a feeling of confirmation when nurses understood them and took them seriously" (Rchaidia, Dierckx de Casterle, De Blaeser, & Gastmans, 2009, p. 536). Chen and Hsu (2015) listed 33 traits identified and described by nurses as characterizing a good nurse. The top 20 traits were: patient, responsible, cautious, friendly, considerate, enthusiastic, caring, sincere, attentive, diligent, respectful, engaged, intimate, cheerful, merciful, encouraging, soothing, courteous, fair, and confident.

Music is thought to serve as a distractor, help people go to a mentally relaxing place, and release endorphins and reduce catecholamine levels.

The characteristics of caring, presence, compassion, excellent nursing skills, and a pleasant personality may be the nurse's goal, in which case he or she is likely to be remembered as a "good nurse" or even a "great nurse." Christian nurses can offer Christ-like compassion. In 1 John 4:7 and 8, we are instructed to love one another, for God is love. The love we show others comes from the love we first have received from God. When I was in the hospital, I was cared for by a large number of excellent nurses, as well as CNAs. Among all the caregivers, one stood out as a Christian in an indisputable way. He took his role seriously as a CNA and at the same time displayed the joy he felt in caring for others. It wasn't so much what he did, although he was quick to try and meet patients' needs; it was his humble servant attitude in all the ways he ministered to patients.

How can Christian nurses proceed if they want to impact the corner of the world in which they have an influence? We start by having a deep spiritual walk through studying, memorizing, and meditating on Scripture (2 Timothy 2:15); personal times of prayer; and fellowship with other Christ-followers. As nurses, we can impact the lives of patients and families with the love of Christ shining through our professional lives.

TIME OF THANKSGIVING

After 4 weeks in the hospital, I was discharged. Discharge planning can be a creative process, if hospital professionals, patients, and patients' families work together to find the best individualized solution for each patient's situation. I developed a plan tailored to my specific needs and made arrangements for home health, staying with my sister and brother-in-law for 3 months. I saw God's provision in that I was not alone, and their house is on one level (my house was a split four-level). A friend from church came every morning and wrapped my leg in an Ace bandage before he went to work. Another sister and other friends took me to medical appointments. At the time, I was teaching in a graduate nursing program, and students came to the hospital or to my sister's house for appointments. I felt like God rained blessings upon me from all directions. I am grateful for all the people who prayed for me and are still praying.

I continue to have right foot-drop and need to wear a foot and leg brace at all times, but I am able to walk with a cane. The pain I experienced was both nociceptive and neuropathic in nature. Pain is still a part of my life but is nothing in comparison to what it was during hospitalization and the first weeks after discharge. Although this has been a difficult time, it has also been a time of abundance and blessing. At times, I wept in sadness for the loss of normal mobility. At other times, I wept as I contemplated the love and provision of God. His presence has been, and continues to be, a powerful sustaining force in my life.

Web Resources

- Post-Operative Pain Management Guidelines—http://www.jpain.org/article/S1526-5900(15)00995-5/abstract
- Teach-Back Method—http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/healthlittoolkit2-tool5.html
- International Association for the Study of Pain—http://www.iasp-pain.org/

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