Original Article

Nurses' Attitudes Toward Patients with Sickle Cell Disease: A Worksite Comparison

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Abstract:

Individuals with sickle cell disease (SCD) have reported being stigmatized when they seek care for pain. Nurse attitudes contribute to stigmatization and may affect patients' response to sickle cell cues, care-seeking, and ultimately patient outcomes. The purpose of this cross-sectional, descriptive, comparative design study was to determine whether there are significant differences in nurse attitudes toward patients with SCD by worksite—medical-surgical units compared with emergency departments/intensive care units (ED/ICU). The sample consisted of 77 nurses (36 nurses from the ED/ICU and 41 from medical-surgical units) who completed an anonymous online survey. No significant differences were noted in attitudes by worksite, with nurses from both sites demonstrating high levels of negative attitudes toward patients with SCD. Findings suggest that nurses from both worksites need additional education about SCD and care of this vulnerable, patient population.

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BACKGROUND

Many individuals with chronic illnesses are living longer. The role of self-care in these disease states has been increasingly studied in recent years given its importance to managing the disease process over time. Chronic disease management involves self-care that is highly individualized. To successfully perform self-care behaviors, individuals must be able to recognize and interpret evolving problems that are unique to their bodies (cue recognition), and then use specific strategies such as seeking medical help to address those problems (cue response). Cue recognition and response are important for individuals living with sickle cell disease (SCD). Negative nurse attitudes may affect patients' response to sickle cell cues, thus affecting clinical care and ultimately patient outcomes. It is important to understand nurse attitudes toward patients with SCD and to determine if these attitudes differ by worksite. The limited studies that have reported nurse attitudes

toward patients with SCD have either focused on the emergency department (ED) or have not specified a worksite. The purpose of this study was to determine whether there are significant differences in nurse attitudes toward patients with SCD by worksite—medical-surgical units compared with ED/intensive care units (ED/ICU).

Challenges of Care-Seeking for SCD

Sickle cell disease is the most common genetic disorder in the United States (Pack-Mabien & Haynes, 2009). It is an inherited blood condition that results in a genetic defect in the hemoglobin structure (Creary, Williamson, & Kulkarni, 2007), leading to the classic sign of sickle-shaped red blood cells. The sickled red blood cells cause hemolysis, which leads to anemia and other complications that can affect every system in the body. They may also lead to irreversible damage (Zack-Williams, 2007). The clinical manifestations of SCD are primarily caused by two mechanisms: hemolysis and vaso-occlusion. Hemolysis is the most recognizable sign of SCD. The average hemoglobin of an individual with SCD is 6 to 9 g/dL (Howard & Oteng-Ntim, 2012; MacMullen & Dulski, 2011) compared with the norm of 13.8 to 17.2 g/dL for males and 12.1 to 15.1 g/dL for females (MedlinePlus, 2014). Another major clinical feature, vaso-occlusion, results in acute pain. These pain episodes have been characterized as sickle cell crises or pain crises. In a critical reappraisal of sickle cell pain, Ballas, Gupta, and Adams-Graves (2012) agreed with Diggs' (1956) description of sickle cell pain as typically being sudden onset in the low back, or one or more joints or extremities. It can be confined to one area or it can migrate and the pain is often continuous and throbbing. These crises are the primary reason for health care utilization and they often result in hospitalizations (Lattimer et al., 2010).

Care for sickle cell crises is typically sought after strategies at home have been exhausted with no relief and the pain has reached unbearable levels (Jenerette, Brewer, & Ataga, 2013). Individuals who present to the hospital in sickle cell crises often are stabilized in the ED with fluids, oxygen, and pain medication then discharged; however, discharge does not necessarily indicate resolution of the crisis (Ballas et al., 2012). More severe cases or cases worsened by delayed analgesia result in admission for further symptom management and/or treatment of the underlying problem (Ballas, 2011). Beyond the ED, inpatient assignment, nursing unit or ICU, is based on patient status and bed availability. Inpatients with SCD are often assigned to medical-surgical units because hospitalists are increasingly more likely to manage inpatient admissions of adults with SCD (Smith, Jordan, & Hassell, 2011); therefore, medical-surgical nurses are seeing an increased number of patients with SCD (Matthie, Brewer, Moura, & Jenerette, in press).

Regardless of the ED, ICU, or inpatient unit, nurses are the chief providers of direct clinical care and interact most often with patients. They are essential for pain management, health education, and prevention of subsequent sickle cell crises (Valente et al., 2010). Nurses not only communicate patient status and concerns to the primary care provider, but they also offer recommendations based on nursing judgment and implement prescribed therapy. In doing so, nurses assume a large percentage of the responsibility to serve as patient advocates. Attitude can serve as a barrier between a nurse and a patient. Before entering nursing school, many nurses develop negative attitudes about pain and the use of opioids for pain management as a result of their ethnic background, values, family, church, and community (Pack-Mabien, Labbe, Herbert, & Haynes, 2001). Having preconceived notions about pain can result in imprecise pain assessments and thus insufficient treatment of pain.

The pain management process can be difficult for all involved because individuals with chronic pain may not show visible signs of pain. Nurses must rely on the patient's subjective description of pain to guide assessment and treatment. Thus, the mantra that pain is "whatever the experiencing person says it is, existing whenever the experiencing person says it does" (McCaffery, 1968, p. 95) should guide practice. This does not always occur. Persons with SCD report being discriminated against, being stigmatized by health care providers, feeling as though their complaints are ignored, and just being poorly treated when they access the health care system (Jacob, 2001; Jenerette & Brewer, 2010; Todd, Green, Bonham, Haywood, & Ivy, 2006).

Vaso-occlusion, a cause for pain in SCD, may lead to other complications such as infection, acute chest syndrome, stroke, renal dysfunction, retinopathy, avascular necrosis, and cholelithiasis (Howard & Oteng-Ntim, 2012; MacMullen et al., 2011). Additionally, an increased frequency of pain episodes has been associated with a higher risk for early death (Reddin, Cerrentano, & Tanabe, 2011). Consequently, timely evaluation and treatment is imperative. On the contrary, patients with SCD report long delays in receiving pain medications, insufficient treatment of pain, allegations of being a drug seeker, and a lack of understanding of SCD by providers (Lattimer et al., 2010). Nurses were reluctant to administer high doses of opioids to patients with SCD experiencing an acute pain crisis because they felt they were contributing to the