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ORIGINAL ARTICLE

Communication when patients are conscious during respirator treatment—A hermeneutic observation study

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KEYWORDS
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Summary
Aim: The aim of this study was to observe, interpret and describe nurses' communication with conscious patients receiving mechanical ventilation treatment (MVT) in an intensive care unit (ICU), and to examine if such communication could be interpreted as caring.
Design: Hermeneutic observational study inspired by the philosophy of Gadamer.
Method: Nineteen patients were observed on several occasions for a total of 66 hours, when conscious during MVT.
Findings: A form of caring communication was identified and interpreted as comprising seven themes: being attentive and watchful, being inclusive and involving, being connected, remaining close, being reassuring and providing security, keeping company and using humour and using a friendly approach. Communication that mediated a non-caring approach was also identified and described under two thematic headings, i.e. being neglectful and being absent.
Conclusions: Caring is communicated by the caring act of ''standing-by'' the patient. Caring or non-caring is communicated in non-verbal and verbal communication, in the words used, the tone of voice and behaviour, as well as in the performance of nursing care activities.

Introduction

During the few last years it has gradually become more common to use light sedation when patients receive mechanical ventilation treatment (MVT) in intensive care units (ICU). This regimen has several medical advantages, leading to both shorter MVT time and time in the ICU (Strøm et al., 2010) and even reducing the risks of complications and immobility (Samuelsson et al., 2006). However it also entails the provision by the nurses of a type of care that differs from that given to unconscious patients. For example, it is important to create and maintain functional, caring communication and that patients feel they are understood and can mediate experiences and needs to both nurses and relatives. Meriläinen et al. (2010) reported that patients in an ICU for

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Box 1 Implications for nursing practice and further studies
In order to be able to communicate caring the nurse must:

- have time to get to know the patient and establish functional communication and a relationship which includes a mutual connection between patient and nurse.
- have time to learn to interpret, ''read'' the patient and listen to each person's way of communicating.
- continuity seems vital. It is important that nurses are, aware that they always communicate caring or lack of it by their attitude, body language, words, tune, and when they touch the patient.

Understanding the meaning of the act of ''standing-by'' allows the nurses to apply this knowledge in different contexts but especially when patients are conscious whilst receiving MVT. Further studies are needed to examine the experiences of both patients and nurses of caring communication.

a period exceeding 24-hours have 41—165 direct contacts with other people who are usually unfamiliar with them. Under such circumstances it may be difficult for patients to establish a relationship based on non-verbal communication with nurses as this presupposes continuity. It is, therefore, open to discussion whether it is possible to establish functioning communication as it takes time to communicate non-verbally (Börsig and Steinacker, 1982).

It has been established that patients view the ICU environment as unfamiliar and feel that they have no impact on how it is organised, which leads to dependency, especially on the nursing staff. Being in the ICU involves experiences of discomfort, feelings of pain and panic (Bergbom-Engberg and Haljamäe, 1989; Foster, 2010; Rotondi et al., 2002; Wang et al., 2008). Being voiceless also creates a loss of freedom and personhood (Carroll, 2007) and evokes feelings of frustration and helplessness (Bergbom-Engberg and Haljamäe, 1989; Samuelsson, 2011). Nurses, therefore, have to pay close attention to the patient's efforts to communicate non-verbally. Most previous research concerns experiences from sedated patients or the sedation regimens and levels of consciousness/wakefulness are unreported. Few studies have reported conscious patients' experiences of MVT (Johnson et al., 2006; Karlsson and Forsberg, 2008; Samuelsson, 2011) and their relatives' experiences of visiting conscious patients during mechanical ventilation (Karlsson et al., 2010).

It is vital, particularly in the ICU, to carry out nursing actions that provide comfort and one such significant action is communication. The question raised in this study is: What and how do nurses create and maintain communication with conscious patients receiving MVT and what is mediated in such communication? To our knowledge, no studies have focussed on this issue, including only conscious patients under no or very light sedation. The purpose of this research was to observe, interpret and describe nurses' communication with patients conscious whilst receiving MVT in an ICU, and to determine whether this communication could be interpreted as caring. The following question guided the study: Does communication between the nurses and the conscious patients mediate caring?

Theoretical framework

The study took its theoretical starting point in Fredriksson's (1999) ideas about caring conversations, where he identified three vital concepts, that is, presence, touch and listening (Fredriksson, 1998). However, in this study we chose to use the term caring communication instead of conversation. Presence is understood as two aspects of a caring presence — *being there and being with*. *Being there* means being physically present and close to a patient, but it also means understanding and communicating and being present for someone. It presupposes attentive behaviour, sensitivity to the patient's body language and needs. *Being with* means that the nurse is available and at the disposal of the patient, and will give of themselves. It also implies an intersubjective encounter between the nurse and the patient, showing the former's willingness to be involved. The nurse remains with the patient even if it is difficult to endure the other's suffering and discomfort. Being with means that patients invite the nurses to enter into their experiences and when the nurses accept this invitation the situation becomes shared.

According to Fredriksson (1999) touch can be described in terms of non-contact and contact touch but refers rather, to a way of relating. Non-contact touch is eye contact, rounding and frowning. Both non-contact touch and contact touch can be divided into three categories:

- task-oriented touch, i.e. that which occurs when a nurse is carrying out a task with no intention of communicating,
- protective touch, i.e. that used to prevent an accident and to protect nurses from emotional feelings,
- caring touch, i.e. that used as a form of non-verbal communication, carrying the message of caring and acceptance of the other as a unique person.

Caring touch results in feelings of security and comfort, reality orientation and enhancement of self-esteem. Protective touch is seen as the opposite to caring touch. It communicates bad feelings to both nurse and patient, as it is a form of distancing oneself from emotional pain and of releasing tension (Fredriksson, 1999).

Listening is an active process and encompasses understanding and interpretation of what is said. Listening is more than hearing to hear is to be aware of the sound and that somebody is saying something. Listening means being silent and trying to receive the message, to hear the tone, read the non-verbal signs and enter the patient's world. With reference to the conscious patient receiving MVT ''listening'' means being aware of the patient's eye and hand movements and facial expression. According to Fredriksson (1999) listening is an intentional act and encompasses concentration; whilst hearing, sound waves are entering our ears and being transmitted to the brain.