ABSTRACT

This study was designed to outline the issues in the care of ventilator patients that represent serious communication problems. The purpose of the study was to determine the nature of communication between the patient and the nurse during the mechanical ventilation process. Duldt's theory of Humanistic Nursing Communication served as the theoretical framework for this study.

Using questionnaire rating scales, 15 ventilator patients and 15 nurses who had cared for those patients indicated their perceptions of the ventilator care situation. Particular attention was given to factors which may represent dehumanizing communication.

The study evidenced support for Duldt's theory of Humanistic Nursing Communication. The perceptions of patients and nurses differed significantly concerning problematic aspects of the ventilator care situation. These results have implications for future research dealing with dehumanizing patterns of communication in critical care settings.

COMMUNICATING WITH THE PATIENT REQUIRING MECHANICAL VENTILATION

A Thesis

Presented to

the Faculty of the School of Nursing

East Carolina University

In Partial Fulfillment

of the Requirements for the Degree

Master of Science in Nursing

by

Ann Perkins

May 1986

COMMUNICATING WITH THE PATIENT REQUIRING MECHANICAL VENTILATION

by

Ann Perkins

APPROVED:

CHAIRPERSON Bonnie W. Dudat

COMMITTEE MEMBER W. Howett Hunn

COMMITTEE MEMBER Joyce J. Jerrett

ASSISTANT DEAN OF THE GRADUATE SCHOOL OF NURSING Bonnie W. Dudat

DEAN OF THE GRADUATE SCHOOL Joseph R. Bryllowe

ACKNOWLEDGEMENTS

Without the understanding, concern and encouragement of many, the achievement of this thesis would not have been possible. I am indebted to all the professors who guided my way during the years I have studied at this university.

In particular, I wish to express gratitude to the members of my committee. Dr. Bonnie Duldt, the committee chairperson, has been most supportive and encouraging. The untiring efforts and considerable time from her and the other members, Dr. Garrett Hume, Dr. Mohammed Ahad and Dr. Corre Garrett, are thankfully acknowledged.

My sincere thanks and appreciation go to the patients and staff who helped me to complete this study. Finally, and most importantly, I wish to thank my boyfriend Kevin for his support and patience.

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER I

DEVELOPMENT OF PROBLEM

Introduction

There are several psychological stressors commonly encountered by many critically ill patients. Foremost, is the threat to life. The perceived closeness of death, accompanied by strong emotional reactions can be an extremely stressful experience for the patient. Pain, physical discomfort, and changes in self-image and future plans are also common stressors for the critically ill. The hospitalized patient experiences additional difficulties such as the need to adjust to the unfamiliar and often confusing hospital environment and separation from family and friends (Cohen and Lazarus, 1979). Patients with chronic respiratory ailments, or victims of severe respiratory difficulties, are subjected to an additional stressor. These patients are often placed on mechanical ventilators. One result of mechanical ventilation is the inability to speak. Due to trauma and/or medication, some patients are also unable to write. This resulting inability to communicate with the staff and with visiting family and friends is widely recognized as a major problem for ventilator patients (Castillo and Egan, 1974; Hudelson, 1977; Lawless, 1975; Martz, Joiner, and Shepherd, 1979).

Generally, patients experience a sense of loss of control when placed in the hospital (Taylor, 1979). The inability of ventilator patients to communicate may further adversely affect the patient's sense of control over the environment, leading to feelings of helplessness and despair. The inability to communicate effectively may also trigger negative emotional reactions such as fear, frustration, and anger. Such extreme emotional reactions can negatively affect the course of the illness (Riggio, Singer, Hartman and Sneider, 1982, p. 364).

There is a large body of literature that attests to the importance of establishing effective lines of communication between patients and health care workers (Wlody, 1984; Riggio, et al, 1982; DiMatteo, 1979; Francis, Korsch, and Morris, 1969; Korsch, Gozzi, and Francis, 1968; Wilson and Bloom, 1972). In ventilator care, establishing good staff-patient rapport can be made more difficult by the patient's inability to communicate. In addition, interaction between patients and families may also be hampered by the patient's inability to speak.

Communication problems between hospital inpatients and staff have received considerable attention in the literature; however, little information can be found on communication difficulties of ventilator patients in intensive care units. Borsig and Steinaker from West Germany clearly address the problem as they write:

> "One can scarcely imagine the fear and uncertainty which often arise, not only in the patient who is not understood, but also in the person caring for him who cannot understand him ... Even nurses and doctors who have worked in such a unit for a long time and have treated and cared for many patients, continually face the difficulty of being unable to understand or interpret correctly what the patient is trying to say" (Borsig and Steinacker, 1982).

Unfortunately, there appears to be a tendency for staff to interact in a dehumanizing manner in the health-care system (Patterson and Zderad, 1976, p. 113). Patients frequently describe their experiences on the ventilator as unpleasant. Perhaps the greatest challenge in caring for the mechanically ventilated patient is to help him feel whole and unique, despite attachment to a machine. In a busy intensive care unit, a nurse can easily fall into the dehumanizing trap of nursing the machine and not the patient.

The first step in treating the patient as a unique human being is to establish a humanistic mode of communication. The heart of humanistic communication is how an individual is valued and treated. It is through humanistic communication that the nurse can develop increased sensitivity and understanding to the problem and develop a better means of communicating with the ventilator patient.

"To humanize means to build relations and to make contact between people; to dehumanize is to break down interrelationships and lose contact between people" (Duldt, Giffin and Patton, 1984, p. 3). To be humanistic means to be aware of the uniqueness of each individual; to be dehumanizing is to ignore these characteristics (Duldt and Giffin, 1985, p. 251).

Purpose and Research Question

The purpose of this study was to determine the nature of communication between the nurse and the patient during the mechanical ventilation process. The research question for this study was thus, "Is there a relationship between the perceived communication efforts of both the nurse and the patient during the mechanical ventilation process?"

Theoretical Basis

Duldt's humanistic nursing communication theory has interdependent and reciprocal relationship statements. This study is designed to test the following relationship statements:

1. "The degree to which one receives humanizing communication from others, to that degree one will feel recognized and accepted as a human being.
    a. While applying the nursing process, the degree to which a nurse is able

> to use humanizing communication, to that degree will the client, peer, or colleague tend to feel recognized and accepted as a human being" (Duldt and Giffin, 1985, p. 248).

One of the assumptions of this theory is that "the goal of the humanistic nurse is to break the communication cycle of dehumanizing attitudes and interaction patterns, replacing these with attitudes and patterns that humanize" (Duldt and Giffin, 1985, p. 251). This theory stresses the importance of conveying personalized concern for the patient such that the patient in return will feel unique and valuable. Emphasis of this theory is placed upon the communication process itself. The essence of the individual can be more clearly represented through use of humanistic nursing communication.

Effective communication is maintained when nurses are comfortable with their own styles of communicating while respecting the needs of the patients. Nurses demonstrate their concern for patients with verbal messages, with nonverbal messages (such as facial expression or touch), and by their thoughtful behaviors (such as massages or frequent visits). Generally, whatever the communication content or style of the individual nurse, most patients are able to perceive the interpersonal intent of the message and respond in a meaningful manner.

Duldt's theory contends that the patient's perceived humanistic communication will tend to become equal to the nurse's humanistic communication.

Consideration of the patient who does not develop some rudimentary communication technique during hospitalization is explained by Duldt as she writes, "Alienation is created when one person decides it is useless to continue trying to communicate with another and therefore refuses to interact" (Duldt, 1981, p. 641). Paraphrasing Patton and Giffin, Duldt continues,

> "'Please validate me' is covertly conveyed as soon as any communication is initiated. The recipient can: a) agree and covertly convey validity and worth to the person and his idea; b) disagree with the idea, but yet covertly convey validity and worth to the person; or c) deny existence of the communicative act, thus covertly denying validity and worth to both the individual and his idea" (Patton and Giffin, 1980, p. 144).

When the nurse denies existence of the communicative action or when communication attempts fail, patients may use anger to communicate with the staff. The angry, hostile patient often precipitates withdrawal of nursing and medical personnel from the patient's environment, increasing the communication

void and enhancing patient and nurse frustration. It is through use of humanistic nursing communication that this chain is broken (Duldt, 1982, p. 170).

Assumptions

1. Ventilator patients and nurses caring for those patients have communication difficulties.
2. Patients perceive mechanical ventilation as a stressful event.
3. Information given by subjects reflected their true feelings.

Limitations

1. Data collected for this study was obtained from one large teaching hospital.
2. The time span for data collection was limited.
3. The sample size was limited to fifteen patients and fifteen nurses.

CHAPTER II

LITERATURE REVIEW

Communication, particularly verbal expression, is seriously impaired for patients who require mechanical ventilation. Patients are limited in their capacity to meaningfully interact with their environment because they are unable to ask questions, make requests, or verbalize feelings. Often patients who are unable to verbally express themselves are viewed as unresponsive to their surroundings; as a result, the patient is not involved in his or her own plan of care (Belitz, 1983, p. 42).

The communication impairments can cause patients to feel powerless to maintain control over themselves or to influence their world. Patients can withdraw from the significant people in their environment because of their frustration, sense of powerlessness, and sense of unimportance. Many patients feel inadequate and alone; however, they must remain dependent on others to satisfy their basic needs (Belitz, 1983, p. 43).

According to Levine (1981), communication in a hospital environment primarily deals with accomplishing tasks and adjusting social-emotional issues. It is an art whose skillful practice is essential to maintaining a wholesome therapeutic environment (p. 218).

There is a large body of literature that attests to the importance of establishing effective lines of communication between patients and health care workers (DeMatteo, 1979; Francis, Korsch and Bloom, 1972; Korsch, Gozzi and Francis, 1968; Riggio, et al, 1982; Wilson and Bloom, 1972; Wlody, 1984). In ventilator care, establishing good staff-patient rapport can be made more difficult by the patient's inability to communicate.

Riggio, et al, 1982, investigated several psychological issues in the situation of the patient on continuous mechanical ventilation. A multi-faceted approach was utilized by direct observation of patients on ventilators, interviews with ventilator patients, their families, and the respiratory care staff, and self-ratings of all three groups (patients, relatives, and hospital staff) on various aspects of the ventilator-care situation. The most critical issues cited from this study were problems in communication, patient's disorientation and loss of memory, emotionality, pain and discomfort, and hospital services (e.g., treatment of patients by staff) (p. 365).

Lawless (1975) surveyed patients and nurses in an intensive care unit (ICU) using two non-standardized questionnaires. She found patients' needs in the ICU as relating to communication, pain medication, air, suctioning, and temperature control (p. 2151). She identified three methods of communication: 1) pad and pen, or Magic

Slate board; 2) hand signals or sign language; and 3) visual aids such as pointing to letters on an alphabet. She identified forming words as if whispering as the most common way to communicate, and the most easily understood by others (p. 2152).

Bothamly (1975) and Gardiner (1978) studied the need for communication with the ventilator patient. Gardiner (1978) emphasized that the fear in these patients is very real and that no two patients will react in the same way due to culture, previous experience, race, and philosophy of life. She also noted that highly anxious and critically ill patients require repetition of explanations (p. 8). Baxter (1975) stressed that nurses dealing with ventilator patients need to learn to carry out one-sided conversations (p. 22). Gardiner (1978) advocated the presence of families as a comfort which reassures the patient who may feel socially isolated in a strange environment and unable to talk (p. 105).

Numerous articles have been written to describe the technical aspects in the care of patients with ventilators (Albanese and Riley, 1980; Kirilloff and Maszkiewicz, 1979; Moir, 1978; Sandham and Reid, 1977; Sitzman, 1972; Trout and Shapiro, 1974; and Tyler, 1973). However, only two research articles relate to the concerns or interpersonal needs of the ventilator patient.

Riddle (1979) ascertained the needs of the temporarily aphonic client and methods by which these needs are

communicated. She submitted a questionnaire to nurses in the ICU. Needs were described as easily communicated, difficult to communicate, or extremely difficult to communicate. She accepted the hypothesis that "Nurses will report more difficulty in understanding the methods used by clients to communicate their psychosocial needs than those methods used by clients to communicate their physical needs" (p. 36). She found the following methods used by patients to communicate their needs: gestures, pointing, writing, mouthing words, changing behaviors, facial expressions, forming letters or words in the palm of a hand, restlessness, respiratory difficulty, and attempting to perform beyond ability (p. 36). She stressed the need to maximize the use of nonverbal communication with the temporarily aphonic patient. She noted that nurses also need to document the needs of the intubated patient and how they may be met (p. 37).

Biggerstaff (1978) interviewed patients using a questionnaire guide consisting of 12 statements. Subjects responded to each item according to degree of concern. Biggerstaff (1978) analyzed responses to the 12 concerns using a Likert-type scale. Her findings identified the most important concerns as the inability to communicate and discomfort from the tube (p. 28). The least important concerns related to ability to breathe and to body image (p. 28).

Belitz, 1983, documented that communication problems can cause ventilator patients to feel powerless to maintain control over themselves or to influence their world. Patients can withdraw from the significant people in their environment because of their frustration, sense of powerlessness, and sense of unimportance. Many patients feel inadequate and alone; however, they must remain dependent on others to satisfy their basic needs (p. 43). Belitz recommends that nurses treat each patient as "an individual with a multidimensional personality who has the ability to think and feel and the need to meaningfully interact with the environment" (p. 44).

Contemporary research has brought about a new mode of communicating with ventilator patients. The computer is widely described in the rehabilitation and speech therapy literature (Downing and Tully, 1979; Morasso, Penso, Suetta and Tagliasco, 1979; and Pierson, 1982). Because of their size or specificity to a certain population many computers are practical for the ventilator patient. A wide range of thoughts and feelings can be communicated on the computer. However, several variables help determine the patient's ability to communicate through use of the computer: physical strength, mental alertness, motivation and staff involvement (Cronin and Carrizosa, 1984).

The previous literature review has indicated that the inability to effectively communicate is a strong source of

stress for both patients requiring mechanical ventilation and the nursing staff caring for these patients. The literature has shown that ineffective communication may produce negative emotional reactions such as fear, frustration and anger. Such extreme emotional reactions have been documented to adversely affect the course of the illness. Perhaps the greatest challenge for nursing staff caring for the ventilator patient is the establishment of an effective and humanistic mode of communication.

CHAPTER III

METHODOLOGY

Introduction

Duldt's humanistic nursing communication theory and studies of communicating with ventilator patients were discussed and examined in previous chapters. The influence of several factors was seen to determine the communication efforts of both the patient and the nurse. The literature review yielded insight into the problem of ineffective communication.

Setting

The study dealt with subjects obtained from five critical care units at a large teaching hospital in eastern North Carolina. The units included a ten-bed coronary care unit, a ten-bed medical care unit, a ten-bed neurosurgical care unit, a ten-bed surgical care unit and a five-bed unit for cardiac surgery patients. Registered nurses staffed all the units in a 1:2 or 1:3 nurse-patient ratio. These different units provided a large accessible population of patients requiring mechanical ventilation.

Subjects

Fifteen patients and the fifteen nurses caring for those patients were selected from the critical care units. Each patient met the following criteria:

1. Adults, ages 18-75.
2. 2-7 days after mechanical ventilation had been discontinued.
3. Conscious and rational, able to understand and respond to the questionnaire.
4. Not in acute distress at the time of the interview.

Those patients unable to hear, or speak, or who had a previous diagnosis of mental retardation, brain damage, head injury, or cerebral edema were excluded.

Each of the nurses used in the study met the following criteria:

1. Practicing in a critical care setting for more than three months or less than four years.
2. Had recently cared for the patient chosen for this study during the time the patient was receiving mechanical ventilation.

The demographic factors of sex, education, marital status, race and religion were not considered in the selection of participants for inclusion in this study.

All participants were screened by the investigator, with consultation from the hospital staff, for identification of clients who met the criteria for inclusion in the study. Data contained in the medical records, particularly psychological/neurological evaluations for orientation and alertness, were also used for this determination.

Procedures

The general hospital's suggested protocol for submitting research projects to the institutional review board was followed. Meetings were arranged with the Vice-President of Nursing Services, Critical Care Administrator and Head Nurses to explain the study and request authorization to use the various units within their agency for research. A formal proposal of the study was submitted to the Institutional Review Committee and the investigator personally explained the proposal to the committee. The committee voted approval on March 3, 1986 (Appendix A). Meetings were then arranged with the Nursing Administrators and the study details were explained. The Head Nurses informed the nursing staff that approval had been granted for this study.

A formal proposal, consent forms, a copy of the questionnaires and a brief abstract of the study were submitted to the Policy and Review Committee on Human Research at East Carolina University. This committee granted permission for the study on February 12, 1986 (Appendix B).

Human Rights

The researcher approached each eligible subject to verbally explain the study and to request participation (Appendix C). A consent to participate was requested prior to each interview. The consent assured each subject's

right to anonymity, confidentiality and adequate explanation (Appendices D and E).

The questionnaires were numerically coded for tabulation. Each participating critical care unit received a summarized report of this study in June of 1986.

All participants were advised that there were no right or wrong answers in answering the questionnaires. The questionnaires were administered and responses recorded by the investigator for all subjects in order to keep conditions the same for all subjects. The subjects were interviewed in a quiet room, without anyone present except the investigator in order to assure confidentiality.

Upon completion of the interviews the researcher expressed verbal appreciation to each participant. A note of appreciation was sent to Nursing Administrators, Head Nurses, and each individual critical care unit for their cooperation and assistance with the study.

Instruments

Each instrument packet used to collect data for the study contained two questionnaires, one for the patient (Appendix F) and one for the nurse who had cared for that patient (Appendix G). Demographic data such as age and illness was recorded on the patient questionnaire. The age of the nurse and the length of time the nurse had been practicing in critical care was included on the nurse

questionnaire. The tools consisted of fifteen statements aimed at identifying major concerns of the patient and the nurse during the mechanical ventilation process.

The questionnaires were administered to a random sample of patients and nurses who met the criteria for inclusion. This pilot study served to identify problems with the questionnaires which were addressed before the actual data collection began.

CHAPTER IV

FINDINGS

The Sample

Thirty subjects provided data for this study. The sample consisted of fifteen patients and fifteen nurses who had cared for those patients. The patient age range was 33-74 years with a median age of 54. The nurse age range was 20-43 with a median age of 23.6 (See Table 1).

Length of time on the ventilator ranged from 1-14 days with a median of 2.75. Six (40%) subjects were on the ventilator for less than two days. Two (13%) subjects required mechanical ventilation for 10-14 days.

Four (27%) subjects required mechanical ventilation following thoracic surgery, four (27%) others due to chronic obstructive pulmonary disease (COPD) and three (20%) subjects required ventilation after abdominal surgery. One subject had developed sepsis prior to discharge and was placed on mechanical ventilation. The remainder of the subjects (20%) were receiving ventilation due to respiratory arrest/failure.

The range for length of time as a registered nurse (RN) in critical care was 3 months-4 years with a median of 1.7. Six (40%) subjects had practiced in a critical care setting for 1-2 years.

TABLE 1

Data of the Total Subject Group

Patients				Nurses			
	Frequency	Percentage	Median		Frequency	Percentage	Median
Age:				Age:			
33-39 years	1	7		20-23 years	3	20	
40-46 years	2	13		24-27 years	5	33	
47-53 years	3	20		28-31 years	3	20	
54-60 years	3	20		32-35 years	2	13	
61-67 years	4	26		36-39 years	1	7	
68-74 years	2	13		40-43 years	1	7	
			54 years				23.6 years
Length of Time on Ventilator:				Length of Time as an RN in Critical Care:			
1-2 days	6	40		3-6 months	1	7	
3-4 days	2	13		7-12 months	4	26	
5-7 days	3	20		1-2 years	6	40	
7-10 days	2	13		2-3 years	3	20	
10-14 days	2	13		3-4 years	1	7	
			2.75 days				1.7 years
Reasons for Mechanical Ventilation:				Length of Time as a Practicing RN:			
Thoracic Surgery	4	27		3-6 months	1	7	
Abdominal Surgery	3	20		7-11 months	1	7	
Respiratory Arrest	1	7		12-23 months	3	20	
Respiratory Failure	2	13		2-3 years	4	26	
Chronic Obstructive Pulmonary Disease	4	2		4-5 years	1	7	
Sepsis	1	7		6-9 years	2	13	
				10-13 years	2	13	
				13-16 years	1	7	
							23.8 months

The range for length of time as a practicing RN was 3 months-16 years with a median of 23.8 months or approximately two years. Four (26%) subjects had practiced as an RN for 2-3 years. One subject had been a practicing RN for fourteen years.

Presentation of Data

A Likert-type scale was used to examine data to rate the perceptions of the patients and the nurses. The investigator assigned a numerical value to each of the seven possible ratings: -3 = "strongly disagree," +3 = "strongly agree" and 0 was assigned a neutral value (See Appendices F and G). Assigned values were then subtracted (nurse score - patient score) for each of the fifteen items included on the questionnaires. Table 2 shows the median score for both the patient and the nurse on each of the fifteen items. Nonparametric sign testing was used to analyze the data from the matched pair (nurse-patient) design. Significance was demonstrated at $p \leq .05$ (Schefler, 1984).

Table 2 evidences that item 7, ignoring the patient while looking after the equipment, shows the most significance (.003). Item 9, remembering minor details in care without prompting, shows significance at .006. Item 2, sufficient time to respond to questions, shows a minimum significance of .057. Item 4, sensitivity of feelings, needs and fears shows a minimum significance of .057.

TABLE 2

Questionnaire Scoring and Significance Level of Nurse - Patient Pairs

Issues/Questions	Median Scores Nurse	Patient	Sign Test p	
1. Offered an appropriate means of communication	1.25	1.69	1.00	
2. Sufficient time to respond to questions	2.00	1.00	0.057	+
3. Burden to the staff	1.72	0.75	0.059	+
4. Sensitivity of feelings, needs and fears	1.43	0.80	0.057	+
5. Encouragement of self-care activities	1.60	1.13	0.065	
6. Treated as a special and unique being	1.58	1.00	0.270	
7. Ignoring patient while looking after equipment	-2.38	-1.33	0.003	*
8. Comfortable while revealing awkward and embarrassing needs	1.40	0.80	0.15	
9. Remembered minor details of care without prompting	-1.0	1.67	0.006	*
10. Surprise concerning choices in care	1.38	1.69	0.77	
11. Acceptance of anxieties and fears	2.38	1.66	0.09	
12. Choice regarding own care	1.72	1.66	0.77	
13. Effective communication	1.33	1.57	1.00	
14. Feelings of helplessness	1.75	1.20	0.42	
15. Problems with memory and awareness	-1.0	0.80	0.09	

* $p \leq .05$ + $p \leq .06$

Item 3, perception as a burden to the staff, shows significance at .059. The least significant items of the questionnaire were 1, offered an appropriate means of communications, and 13, effective lines of communications. Both of these items were found to be of no significance at 1.0.

CHAPTER V

SUMMARY

Discussion

This study was designed to test the following relationship statements from Duldt's humanistic nursing communication theory:

1. "The degree to which one receives humanizing communication from others, to that degree one will feel recognized and accepted as a human being.
   a. While applying the nursing process, the degree to which a nurse is able to use humanizing communication to that degree will the client, peer or colleague tend to feel recognized and accepted as a human being" (Duldt and Giffin, 1985, p. 248).

The research question for this study was, "Is there a relationship between the perceived communication efforts of both the nurse and the patient during the mechanical ventilation process?" According to the study data, there were significant statistical relationships between the perceptions of the patients and the nurses.

Results indicate support for Duldt's humanistic communication theory. The most significant relationship

was Item 7, ignoring the patient while looking after the equipment. Five items showed large relationships between the two designated groups. According to Table 2, all fifteen of the items had specific relationships as evidenced by the differences in the median scores.

There were significant differences in how patients and nurses responded to the 15-item questionnaires. The patients tended to make more extreme responses, marking toward one end of the scale or the other; the nurses made more use of the entire length of the scale. Consequently, responses were analyzed using a nonparametrical statistical technique, sign testing (Schefler, 1984).

The significant discrepancy in patients' perceptions of the ventilator-care situation and the nurses' perceptions of the same situation is puzzling. Perhaps the nurses, when rating aspects of care, are more prone to remember the worst cases--culminating in ratings that indicated that many issues presented serious problems for patients. On the other hand, patients may undergo a process of denial, so they do not remember many of the negative aspects of their care.

Initial interviews and previous research led this investigator to believe that problems in communicating would have important significance in the care of the patient requiring mechanical ventilation. The responses of the ventilator patients and the nurses caring for these patients

did not indicate the previous assumption. Moreover, this did not appear to be simply a response bias, i.e., certain patients were not inclined to see every issue as being problematic or non-problematic. Patients who did not report having communication difficulties often reported problems in areas such as emotionality, feelings of anxiety, fear and discomfort.

Nurses perceived patients as having significantly more problems with feelings of helplessness and discomfort while revealing awkward and embarrassing needs than did the patients. In addition, the nurses perceived patients as experiencing fewer problems with memory and awareness than the patients themselves reported. There were no significant differences in the perceptions of the nurses and patients concerning communication, self-care activities and choices regarding care.

This study was designed primarily to outline the issues in the care of ventilator patients that represent potentially serious communication barriers. A significant proportion of nurses reported that they allowed the patient sufficient time to respond to their questions concerning comfort, positioning and suctioning. The patients reported that they were not allowed sufficient time to respond to those questions. However, contrary to expectations, the majority of patients reported little concern with being offered a means of communication, such as a pen and pad.

Criticism of hospital care was mentioned in initial interviews with patients and by some staff. This finding was not confirmed by this study. Perhaps these findings were based, in part, on the ages of the ventilator patients and the seriousness of their illness. In addition, since previous ventilator patients had survived the intensive care situation, they may have been hesitant to criticize the quality of nursing care. Nurses were significantly more critical of the quality of care given than were the patients. Unfamiliarity with the intensive care environment may also have contributed to the patients' positive ratings of care (i.e., they had nothing with which to compare it).

Perhaps the most striking finding was the differing perceptions of the patient and nurse regarding ignoring the patient while looking after the equipment (Item 7 - Table 2). This is an extremely dehumanizing pattern which Duldt addresses as she writes, "The nurse views the patient as a problem or a disease entity which requires her attention. She is a closed role-playing individual (Duldt, 1984, p. 263). Nurses who work in critical care may feel surrounded by death and illness and succumb to depression and the helpless/hopeless attitude (Newlin, 1978). It is important for critical care nurses to be able to withdraw from a stressful situation. When withdrawal is unavailable or delayed, nurses sometimes respond by presenting a composed and unemotional facade

to their patients. The patient, in turn, interprets this as an uncaring attitude. Weisman, 1981, noted that any nurse who has sustained a relationship with a patient implicitly promises to fulfill or contribute something to good management and care. If a patient expects something of a nurse, then she expects something in exchange.

Item 9 of the questionnaire, remembering minor details of care without prompting, evidenced a significant difference in scoring. The nurses felt that they attended to details of care without the patient having to remind them. The patients perceived the opposite. Perhaps this discrepancy is related to the communication act itself. Newlin (1978) noted that patients are sometimes reluctant to seek assistance from physicians, but will feel more comfortable asking the nurse for assistance. Critical care nurses must be experienced at handling unique machines, coordinating the care of their patients and must interact with other health professionals to develop plans of care for their patients. Nurses working with the terminally ill in the intensive care unit are especially vulnerable to dehumanizing patterns. It is clear to see how the patients' needs might be briefly forgotten by the nurse in a busy intensive care unit.

Item 2, sufficient time to respond to questions concerning comfort, positioning and suctioning, showed minimum significance of $p \leq .06$. The patients felt that they were not

given ample time to communicate their needs. The nurses felt that they allowed adequate time for the patient to respond to their questions. This can be explained, in part, by the nurse's reactions to the stressful environment of critical care. She must make quick decisions about her interventions and thus might expect the same rapid response from her patients.

Demonstration of sensitivity to the needs, feelings and fears of the ventilator patient was another item which showed a minimum significance level. The nurses tended to mark more extreme responses agreeing that they were, indeed, sensitive to the patient. However, the patients marked more neutral responses to this question indicating that they were not in agreement with the nurses. Once again, the issue of dehumanizing patterns arises. Also, patient expectations are not always in congruence with nurse expectations.

Item 3, the perception of the patient as a burden, scored minimum significance. The nurses showed agreement that caring for the ventilator patient is burdensome. The patients disagreed that they were perceived as a burden to the nurse. This finding indicates that the critical care nurses were congizant of the demanding role of the patient receiving mechanical ventilation. Even though the nurses consider the ventilator patient to be a burden,

the patients' response indicates that this perception was not transferred back to the patient.

Item 1, offered an appropriate means of communication and item 13, effective communication, showed very little difference with relation to the nurse and patient scoring. This finding illustrates that both patients and nurses perceived the offering of a means to communicate and the overall communication act itself to be satisfactory.

The issues of choice regarding own care, item 12, and encouragement of self-care activities, item 5, evidence little difference in scoring. This finding demonstrates humanistic communication. The dehumanizing aspect of this interaction could have been that the nurses ordered, issued and expected compliance from the patients. Instead, both patients and nurses agreed that an atmosphere of dialogue was created and appropriate choices were offered to the patients.

Item 10, surprise concerning choices in care, showed that patients and their nurses were surprised to find that, despite attachment to machine, choices regarding care could be made by the patient. Critical care nurses may concentrate so intently on their tasks and procedures of caring for the patient's body that one may experience some degree of surprise when the patient speaks, turns over, or initiates an independent action (Duldt, 1984, p. 264).

Problems with memory and awareness, item 15, demonstrates that there were slight differences in perceptions. The patient median score was higher than the nurse median score. In essence, patients stated that they had more problems with memory and awareness than the nurses actually perceived. Perhaps the nurses, when rating aspects of memory and awareness, are more prone to believe their patients are alert. On the other hand, patients may undergo a process of denial, so they do not remember all aspects of their hospitalization. The interviews for this study indicated that patients tended not to remember details of their experiences while on mechanical ventilation.

Item 14, feelings of helplessness, and item 11, acceptance of fears and anxieties, evidenced that the nurses perceived a slightly higher degree of helplessness in their patients but accepted the fears and anxieties associated with mechanical ventilation. Often times patients are socialized into a submissive manipulative role with limited acceptance of feelings and needs in a closed communicative system (Duldt, 1984, p. 264). This investigator did not find this to be true.

Item 6, treated as a special and unique being, demonstrates that the nurses perceived their interactions with the patients as caring. Treating a person as an individual involves the deliberate use of humanizing

communication attitudes and patterns of communication. "In humanistic nursing, the nurse gives of personal and professional strengths and resources to help the client struggle and strive to survive illness (or to die, to let go), to heal, and hopefully, to achieve wellness of body and spirit. And this caring is reciprocal" (Duldt, 1984, p. 268). The patients agreed that, indeed, their nurses did treat them as special and unique beings.

Implications for Nursing

The data obtained from the questionnaires exhibit the following implications:

1. Further research should incorporate health specific attitudes, beliefs and practices into tools which are developed to measure humanistic communication between patients and nurses.

2. The nurse might study further the relationship and perceptions between patients, nurses, physicians and other health care professionals during the mechanical ventilation process.

3. Discussion and teaching about the communication barriers imposed by the mechanical ventilator should be presented to the patient prior to placement on the ventilator.

These implications are pertinent based upon the review of the literature and the study results. Therefore, in order for the nurse to conduct meaningful research that will

advance the theory and practice of humanistic communication, these implications should be explored.

Limitations of the Study

In this study a sample of convenience consisting of ventilator patients and their nurses was used. Therefore, the results of this study apply only to the subjects in the study. If more broad generalizations about the differing perceptions between patients and nurses are to be considered, it would be necessary to replicate this study using a larger sample in other nursing settings.

In addition, the instruments used to collect data had not been previously used in the clinical setting and the population norms are unknown. The instruments need further development for validity and reliability.

The nature of the patients' illnesses placed several restrictions on the method used to collect data. The interpretation of the data must be done very cautiously. An inability to privately read and record their own responses anonymously may have resulted in the patients and nurses answering in a socially desired manner rather than of their true opinion. Further, variability in the patient's physical condition, such as amount of fatigue, may have resulted in response variations unrelated to the patient's actual opinion.

Lastly, it must be noted that related conditions which might impact the patient's response were not controlled. Among these factors would be the number and severity of existing chronic conditions, prior experiences with hospitalizations and level of functioning following the removal of mechanical ventilation.

Recommendations

The questionnaires require examination and revision prior to use in subsequent studies. The questionnaires include items of general attitude and belief which may or may not transfer to the health specific situation.

Also, the items related to humanistic communication are not given special emphasis in any way, allowing the important effect of valuation to be lost in the final total scoring. These issues should be addressed before further use of the tools is considered. Once that has been accomplished, a further study might examine the correlation of perceptions between patients, nurses, physicians and respiratory therapists during the mechanical ventilation process.

Although the instruments used for data collection in this study need refinement, further research of humanistic communication using the same concepts should be done using larger samples in other settings. Further studies might

explore humanistic communication among a patient group other than ventilator patients. These differences in perceptions of patients and nurses must be considered in future research dealing with critical care patients.

Bibliography

Abrahm, H. S. (1969). Psychological aspects of the intensive care unit. Hospital Medicine, 5(12), 94-95.

Agle, D. P., and Baum, G. L. (1977). Psychological aspects of chronic obstructive pulmonary disease. Medical Clinics of North America, 61(4), 749-758.

Albanese, A. J. and Riley, J. M. (1980). Caring for the intubated patient. RN April, 43(4), 98-100.

Baxter, S. (1975). Psychological problems of intensive care. Nursing Times, 71(2), 63-65.

Biggerstaff, A. (1978). The identification of major concerns of intubated patients and the perceived importance of these concerns. Unpublished manuscript, Emory University.

Belitz, M. A. (1983). Minimizing the psychological complications of patients who require mechanical ventilation. Critical Care Nurse, May/June, 42-46.

Bothamley, V. A. (1975). Communication and the ventilated patient. Nursing Times, 71(16), 628-630.

Börsig, A. and Steinacker, I. (1982). Communication with the patient in the intensive care unit. Nursing Times, 78(12), supplement 1-11.

Castillo, A. and Egan, H. (1974). How it feels to be a ventilator patient. Respiratory Care, 19, 279-283.

Cohen, F. and Lazarus, R. S. (1979). Coping with the stresses of illness. In Stone, G. C., Cohen, F. and

Alder, N. E. (Eds.), Health Psychology, San Francisco: Jossey-Bass, 98-122.

Cronin, L. R. and Carrizosa, A. A. (1984). The computer as a communication device for ventilator and tracheostomy patients in the intensive care unit. Critical Care Nurse, January/February, 72-76.

DiMatteo, M. R. (1979). A social-psychoanalysis of physician-patient rapport: Toward a science of the art of medicine. Journal of Social Issues, 35, 12-33.

Dimond, M. (1979). Social support and adaptation to chronic illness. Research in Nursing and Health, 2, 101-108.

Downing, O. J. and Tully, J. E. (1979). Telecad--a television communication aid for the disabled. Medical and Biological Engineering, 17(4), 476-480.

Dudley, D. and Glaser, G. (1980). Psychosocial concomitants to rehabilitation in COPD. Chest, March, 413-419.

Duldt, B. (1982). Helping nurses to cope with anger dismay syndrome. Nursing Outlook, 30(3), 168-174.

Duldt, B. (1981). Anger: An alienating communication hazard for nurses. Nursing Outlook, 29(11), 640-644.

Duldt, B. W. and Giffin, K. (1985). Theoretical perspectives for nursing. Boston: Little Brown.

Duldt, B. W., Giffin, K. and Patton, B. R. (1984). Interpersonal communications in nursing. Philadelphia: F. A. Davis.

Francis, V., Korsch, B. M. and Morris, M. J. (1969). Gaps in doctor-patient communication: Patient's

response to medical advice. New England Journal of Medicine, 280, 535-540.

Gardiner, B. (1978). Our responsibilities to the person beside the respirator. The New Zealand Nursing Journal, 71(2), 7-11.

Hudelson, E. L. (1977). Mechanical ventilation from the patient's point of view. Respiratory Care, 280, 535-540.

Kirilloff, L. H. and Maszkiewicz, R. C. (1979). Guide to respiratory care in the critically ill. American Journal of Nursing, 79(11), 2005-2012.

Korsch, B. M., Gozzi, E. K. and Francis, V. (1968). Gaps in communication. Pediatrics, 42, 855-871.

Lawless, C. A. (1975). Helping patients with endotracheal and tracheostomy tubes communicate. American Journal of Nursing, 75, 2151-2153.

Levine, E. (1981). Tools for correcting communication problems. Supervisory Practices for Health Care Professionals, March.

Martz, K. V., Joiner, J. and Shepherd, R. M. (1979). Management of the patient-ventilator system: A team approach. (Chapter 17). St. Louis: Mosby.

Moir, J. (1978). Intensive care--6. Nursing care of patients on ventilators. Nursing Times, 74(12), 492-495.

Morasso, P., Penso, M., Suetta, G. and Tagliasco, V. (1979). Towards standardization of communication and

control systems for motor impaired people. Medical and Biological Engineering, 17(4), 481-488.

Newlin, N. J. and Wellisck, D. K. (1978). Nursing: Life on an emotional roller coaster. Cancer Nursing, 1, 447-449.

Patterson, A. D. and Zderad, G. (1976). Factors influencing patients' emotional reactions to hospitalization. Journal of Advanced Nursing, 3(3), 98-118.

Patton, B. R. and Giffin, K. (1980). Interpersonal communication, 3rd edition, New York: Harper and Row.

Reif, L. (1975). The social reconstruction of a disability. Journal of Social Science, 98(1), 71-74.

Riddle, L. D. (1979). Presumed needs of the temporarily aphonic client. Unpublished manuscript, University of Kentucky.

Riggio, R. E., Singer, R. D. and Hartman, K. (1982). Psychological issues in the care of critically-ill respirator patients: Differential perceptions of patients, relatives and staff. Psychological Reports, 51, 363-369.

Sandham, G. and Reid, B. (1977). Some Q's and A's about suctioning and a guide to better techniques. Nursing 77, 7(10), 60-65.

Schefler, W. C. (1984). Statistics for health professionals. Reading, Massachusetts: Addison-Wesley.

Sitzman, J. (1972). Nursing management of the acutely ill respiratory patient. Heart and Lung, 1(2), 207-215.

Sweetwood, H. M. (1979). Nursing in the intensive care unit. New York: Springer.

Taylor, S. E. (1979). Hospital patient behavior: Reactance, helplessness, or control? Journal of Social Issues, 35, 156-184.

Trout, C. and Shapiro, B. A. (1974). Respiratory intensive care nursing. Respiratory Care, 19(5), 361-368.

Weisman, A. D. (1981). Understanding the patient: The syndrome of caregiver's plight. Psychiatry, 44, 161-168.

West, N. D. (1975). Stresses associated with ICU's. Hospitals, 49(24), 62-63.

Wilson-Barnett, J. and Carrigy, A. (1978). Factors influencing communication in hospitals. Journal of Advanced Nursing, 3(3), 221-229.

Wilson, R. N. and Bloom, S. W. (1972). Patient-practitioner relationships. In Freeman, S., Levine, G. and Reeder, L. G. (Eds.), Handbook of Medical Sociology. Englewood Cliffs, New Jersey: Prentice Hall, 124-140.

Wlody, G. S. (1984). Communicating in the ICU. Nursing Management, 15(9), 24-27.

APPENDICES

DEPARTMENT OF PATHOLOGY
PITT COUNTY MEMORIAL HOSPITAL, INC.
P.O. BOX 6028
GREENVILLE, NORTH CAROLINA 27834

Chief of Pathology — (919) 757-4951
Laboratory Administrator — (919) 757-4946

Surgical Pathology — (919) 757-4495
Clinical Pathology — (919) 757-4467

March 3, 1986

Ann Perkins
P.O. Box 1103
Winterville, N.C. 28590-1103

Dear Ms. Perkins:

In the absence of the chairman of the PCMH Institutional Review Committee, Dr. Gene Hamilton, I have reviewed your thesis proposal entitled "Communicating with the Patient Requiring Mechanical Ventilation". It is confirmed that the research proposal qualifies for exemption from federal regulations and therefore exemption from review by the full Institutional Review Committee under paragraph 3 of 45 CFR 46.101 (b).

The study is therefore approved as written for use in this hospital for a period of one year.

Sincerely,

Ernest W. Larkin, M.D.
Vice Chairman
Institutional Review Committee
Pitt County Memorial Hospital

ljm

cc: Kathryn Gaston
Gene Hamilton, M.D.

EAST CAROLINA UNIVERSITY
GREENVILLE, NORTH CAROLINA 27834
POLICY AND REVIEW COMMITTEE ON HUMAN RESEARCH

OFFICE OF THE CHAIRMAN
BRODY BUILDING 6N-70, 6N-74
SCHOOL OF MEDICINE

Telephone (919) 757-2914 (Secretary)
(919) 757-2773 (Chairman)

MEMORANDUM

To: Ms. Anna M. Perkins
P.O. Box 1103
Winterville, NC 28590

From: William H. Waugh, M.D., Chairman UPRCHR Wm. H. Waugh

Subject: Research Project No. 85-145

Date: February 12, 1986

Your research proposal entitled "Communicating with the Patient Requiring Mechanical Ventilation" has been reviewed by this Office and given the UPRCHR identification number 85-145.

This notice confirms for the institution that the project qualifies for exemption from the Federal regulations concerning human research subjects under paragraph 3 of 45 CFR 46.101(b). It is also confirmed that this project is judged to be a no more than minimal risk research proposal.

WHW/pwd

Copy: Dr. Bonnie Duldt, School of Nursing

EXPLANATION OF STUDY TO POTENTIAL SUBJECTS

My name is Ann Perkins and I am a graduate student at East Carolina University. I am doing a research study as a requirement for my Master's Degree. This research has been approved by both my thesis committee and the Human Subjects Review Committee for East Carolina University. I am studying some of the factors and issues in the care of ventilator patients. The data that I am collecting will be used only for this study. Participation in this study is entirely voluntary and participants have the right to refuse to answer any or all questions with no effect on the care that they will receive while at Pitt County Memorial Hospital. If you agree to participate, you will be asked a series of questions. I will assist you in recording your choice. About thirty minutes will be needed to collect this information. I will schedule a time with your approval when you are not involved with therapies. These data will not be used in such a way that you could be identified as a participant.

I hope you will decide to participate in my study. Thank you very much for listening. Do you have any questions? If you have no further questions, are you interested in being part of this study?

APPENDIX D

INFORMED CONSENT

(Patient)

I agree to participate in the study being conducted by Ann Perkins, a Graduate Student in Nursing at East Carolina University. I understand that my voluntary participation will involve responding to questions regarding my experiences while on the mechanical ventilator. This will take about thirty minutes. I understand that this study is in partial fulfillment of the thesis requirement toward completion of the Master of Science Degree in Nursing.

It is herein agreed that responses will not be shared with anyone. As a participant I will remain anonymous and my name will not appear on the answer form; the answer forms will be numerically coded and in no way will my answers to the questions be linked with my name. While requested to complete the questionnaire in its entirety for the purposes of validity of this study, I have the right to refuse to answer any or all of the questions. I understand that I may withdraw from this study at any time and that my refusal to participate will have no effect on the care that I receive from Pitt County Memorial Hospital.

I reserve the right to ask questions about the study, and if, at any time, I feel that my questions have not been adequately answered by the researcher, I may withdraw from the study. I understand that there will be no compensation for my voluntary participation in this study. I may request an explanation of my results in this study from the researcher after all the questionnaires have been completed. I have retained a copy of this consent form.

_____ _____

Date Signature of Patient

_____ _____

Date Investigator

APPENDIX E

INFORMED CONSENT

(Staff Nurse)

I agree to participate in the study being conducted by Ann Perkins, a Graduate Student in Nursing at East Carolina University. I understand that my voluntary participation will involve responding to questions regarding my experiences while caring for patients requiring mechanical ventilation. This will take about thirty minutes. I understand that this study is in partial fulfillment of the thesis requirement toward completion of the Master of Science Degree in Nursing.

It is herein agreed that responses will not be shared with anyone. As a participant I am to remain anonymous and my name will not appear on the answer form; the answer forms will be numerically coded and in no way will the answers to the questions be linked with my name. While requested to complete the questionnaire in its entirety for the purpose of validity of this study, I have the right to refuse to answer any or all of the questions. I understand that my refusal to participate will have no effect on my employment at Pitt County Memorial Hospital.

I reserve the right to ask questions about the study, and if, at any time, I feel that my questions have not been adequately answered by the researcher, I may withdraw from the study. I understand that there will be no compensation for my voluntary participation in this study. I may request an explanation of the results in this study from the researcher after all the questionnaires have been completed. I have retained a copy of this consent form.

_____ _____

Date Signature of Staff Nurse

_____ _____

Date Investigator

APPENDIX F

PATIENT QUESTIONNAIRE

Patient #

Age _____

Length of time on the ventilator _____

Reason or illness that warranted use of mechanical ventilation_____

These questions apply to your experiences while on the mechanical ventilator. Please complete the questionnaire in its entirety. For each numbered item below, please circle your response.

-3	-2	-1	0	+1	+2	+3
Strongly Disagree	Disagree	Slightly Disagree	Neutral	Slightly Agree	Agree	Strongly Agree

1. I was regularly offered an appropriate means of communication (i.e. pen and paper or communication board).

   -3 -2 -1 0 +1 +2 +3

2. I was given sufficient time to respond to the nurse's questions concerning comfort, positioning and suctioning.

   -3 -2 -1 0 +1 +2 +3

3. I felt that I was perceived as a burden to the staff.

   -3 -2 -1 0 +1 +2 +3

4. The nurse demonstrated sensitivity of my feelings, needs and fears.

   -3 -2 -1 0 +1 +2 +3

5. The nurse encouraged me to do things for myself.

   -3 -2 -1 0 +1 +2 +3

6. I was treated as a unique and special human being.

   -3 -2 -1 0 +1 +2 +3

7. I felt ignored while the nurse was in my room looking after the equipment.

-3 -2 -1 0 +1 +2 +3

8. I felt comfortable revealing awkward and embarrassing needs to my nurses.

-3 -2 -1 0 +1 +2 +3

9. The nurse remembered minor details in my care without prompting from me.

-3 -2 -1 0 +1 +2 +3

10. The nurse appeared surprised to see that I could still make some decisions for myself.

-3 -2 -1 0 +1 +2 +3

11. The nurse was accepting of my anxieties and fear.

-3 -2 -1 0 +1 +2 +3

12. I was given choices concerning my care.

-3 -2 -1 0 +1 +2 +3

13. It was usually difficult for me to effectively communicate with the nurse.

-3 -2 -1 0 +1 +2 +3

14. I felt helpless to my environment.

-3 -2 -1 0 +1 +2 +3

15. I had a significant problem with awareness and memory.

-3 -2 -1 0 +1 +2 +3

APPENDIX G

NURSE QUESTIONNAIRE

Nurse #

Age _____

Length of time as an RN in critical care _____

Length of time as a practicing RN _____

These questions apply to your experiences of caring for patients while on the mechanical ventilator. Please complete the questionnaire in its entirety. For each numbered item below, please circle your response.

-3	-2	-1	0	+1	+2	+3
Strongly Disagree	Disagree	Slightly Disagree	Neutral	Slightly Agree	Agree	Strongly Agree

1. I offered this patient a means of communicating (i.e. pen and paper or communication board).

   -3 -2 -1 0 +1 +2 +3

2. I allowed sufficient time for this patient to respond to questions concerning comfort, positioning and suctioning.

   -3 -2 -1 0 +1 +2 +3

3. I sometimes feel that it is burdensome to care for the patient on the mechanical ventilator.

   -3 -2 -1 0 +1 +2 +3

4. I was sensitive to the needs, feelings and fears of this ventilator patient.

   -3 -2 -1 0 +1 +2 +3

5. I encouraged self-care activities.

   -3 -2 -1 0 +1 +2 +3

6. I treated this ventilator patient as a unique and special human being.

   -3 -2 -1 0 +1 +2 +3

7. I sometimes ignored my patient when I was in the room looking after the equipment.

-3 -2 -1 0 +1 +2 +3

8. I encouraged the patient to feel comfortable while revealing awkward and embarrassing needs.

-3 -2 -1 0 +1 +2 +3

9. I sometimes forgot minor details in care and had to be prompted by the patient to remember.

-3 -2 -1 0 +1 +2 +3

10. I was surprised when this patient was able to make decisions about his/her care.

-3 -2 -1 0 +1 +2 +3

11. I tried to accept the fears and anxieties associated with the mechanical ventilator.

-3 -2 -1 0 +1 +2 +3

12. I gave the patient choices with regard to care activities.

-3 -2 -1 0 +1 +2 +3

13. It was difficult for me to effectively communicate with this ventilator patient.

-3 -2 -1 0 +1 +2 +3

14. Being on the ventilator made this patient feel helpless.

-3 -2 -1 0 +1 +2 +3

15. This patient was alert throughout the entire mechanical ventilation process.

-3 -2 -1 0 +1 +2 +3

APPENDIX H

DESCRIPTION OF THESIS

TITLE: Communicating With The Patient Requiring Mechanical Ventilation

PRINCIPAL INVESTIGATOR: Anna Marie Perkins, Graduate Student, School of Nursing, East Carolina University, Greenville, North Carolina 27834

PURPOSE: To answer the following research question: Is there a relationship between the perceived communication efforts of both the nurse and the patient during the mechanical ventilation process?

DESIGN: Using questionnaire rating scales, 15 ventilator patients and 15 RN's who cared for the patients will indicate their perceptions of the ventilator care situation with particular attention given to factors that may represent communication barriers.

SCOPE AND LIMITATIONS: This study is designed primarily to outline the issues in the care of ventilator patients that represent serious communication problems. The study is limited to patients who remained "alert" during the mechanical ventilation process.

SIGNIFICANCE: The inability of ventilator patients to communicate may adversely affect the patient's sense of control over the environment, leading to feelings of helplessness and despair. The inability to communicate effectively

may also trigger negative emotional reactions such as fear, frustration and anger. Such extreme emotional reactions have been observed to negatively affect the course of the illness. If dehumanizing communication can be identified, then efforts can be made to avoid these, thus improving the patient's potential for healing and recovery.

THEORETICAL BASIS: Duldt's theory of Humanistic Nursing Communication will be used to guide this study. This study is designed to test the following relationship statements:

1. "The degree to which one receives humanizing communication from others, to that degree one will tend to feel recognized and accepted as a human being."
2. "While applying the nursing process, the degree to which a nurse is able to use humanizing communication, to that degree will the client, peer, or colleague tend to feel recognized and accepted as a human being."

FINDINGS: This study is currently in process.

EAST CAROLINA UNIVERSITY
GREENVILLE, NORTH CAROLINA 27834-4353

SCHOOL OF NURSING

Telephone (919) 757-6061

TO: Critical Care Units

FROM: Ann Perkins RN BSN
Graduate Student

DATE: March 18, 1986

RE: Research Study

For the next two weeks I will be conducting research in all five critical care units. The purpose of this research is to describe the relationship between the communication efforts of both the patient and the nurse during the mechanical ventilation process. Attached is a brief description of the study. The criteria for patient inclusion in the study are:

1. ventilator patient, male or female, ages 18 to 75;
2. 2-7 days after mechanical ventilation has been discontinued;
3. conscious and rational, able to respond to the questionnaire.

The criteria for RN inclusion in the study are:

1. primary caregiver of the patient selected for study;
2. greater than three months or less than four years as a practicing RN in critical care.

I will make rounds through the units every Monday and Thursday to locate possible candidates for the study. If you find a patient which qualifies for the study, I can be reached at home (355-2292) or at work (757-4813).

I look forward to your participation in this study. If you have suggestions or concerns please feel free to contact me. I welcome any nursing input that you might have to offer. Feedback will be provided to each unit at the end of the study. Thanks again!