



Effective communication in an intensive care setting: Nurses' stories

ABSTRACT

Effective communication has been long considered an important aspect of nurse-patient interactions. However, follow up of people who have been patients in intensive care units (ICUs) indicates that nurses' communication in this setting is at times unsatisfactory. Patients have described how they were left feeling frustrated and alienated by this failure in the communication process and unconscious patients report how they were aware of nurses' attempts at communication with them while unconscious (Lawrence, 1995). Because most of the research to date has focused on patients' perceptions of nurses' communication in an intensive care unit, this study sought to explore what nurses believed constituted effective communication in an intensive care setting. Therefore, a qualitative study was undertaken to explore nurses' perceptions of effective communication with patients in an intensive care setting. The stories of four intensive care nurses were utilised as the means of data collection. The analysed data revealed the following themes: nurses' perceptions, presencing and reassurance. The findings have relevance for nurses in many settings.

KEY WORDS

Effective communication;
Intensive care;
Stories;
Narrative



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INTRODUCTION

The importance of effective communication in intensive care settings is well established. However, anecdotal and research evidence suggests that many patients recover from episodes of critical illness that necessitated admission to an intensive care unit (ICU) with a less than favourable view of the nurses' ability to communicate effectively (Ashworth, 1980). Patients often describe how they felt frustrated and alienated by the apparent lack of communication in these settings. Further, just because patients are unconscious, we can never assume they do not perceive attempts to communicate with them.

LITERATURE REVIEW

Intensive care settings are designed to assist and care for patients with complex, multiple or life threatening health problems. Many of the patients are ventilated and/or chemically paralysed and

sedated. The emphasis in ICUs is on technology and short stays. The environment is often noisy, technical and fear inducing to many patients. Consequently, the psychological outcome is often what is described as an ICU syndrome.

The ICU syndrome is a type of organic brain syndrome manifested by a variety of psychological reactions, including fear, anxiety, depression, hallucinations and delirium (Weber et al., 1985). The patients describe themselves as experiencing some sort of state of chaos, which results in feelings of extreme instability, vulnerability and fear, often experienced as prolonged inner tension (Granbert et al., 1998). This syndrome is thought to be the result of highly technical, unfamiliar surroundings, obtrusive auditory stimuli, difficulty distinguishing between night and day, high levels of discomfort, prolonged emotional tension, sensory overload, and sleep deprivation (McKegney, 1966; Fisher & Moxham, 1984; Weber et al., 1985; Dyer, 1995).

Nursing staff in ICUs are important facilitators of communication because they provide a link between the patient and the outside world. Nurses are said to provide a conduit for initiating and maintaining a modicum of normality in an otherwise alien environment (Morse & Intrieri, 1997). This is important when many of the patients are unconscious, as is the case in this setting. The benefits of communicating with unconscious patients have been explored by a number of researchers such as Manzano et al. (1993). Ashworth (1980) found that there was a reduction in the incidence of the ICU syndrome that was directly proportional to increased verbal communication with unconscious patients. Elliott and Wright (1999), in a participant observational study, in which nurses were interviewed regarding their perceptions of communication with patients in intensive care settings, revealed the following themes related to verbal communication with unconscious patients: procedural/task orientations; orientational information; reassurance; apologies/recognition of discomfort; efforts to illicit a response; intentional and unintentional distraction; social conversation with colleagues while recognising the patient's presence. Further, they claim that medical investigations or interventions led to an increase in

communication, and that 'deeper levels of interaction reflected a deeper commitment to individualized care because the nurse was demonstrating a recognition of the patients uniqueness' (Elliott & Wright, 1999: 1419). However, despite these claims, it remains clear that patients in ICUs are often left feeling denied of effective communication by nurses. Russell (1999) reports that patients' memories of being in an ICU highlighted the presence of power relations inherent in this type of setting. Russel (1999) further reported that the same patients found the lack of good communication quite distressing. Jarret and Payne (1995) found that much of nurses' communication with patients is brief, superficial and often perceived by the patients as controlling. As a result, effective communication is restricted.

Patients who have been cared for in an ICU report how effective communication assists in the prevention of feelings of isolation and alienation (Salyer & Stuart, 1985). These patients have also described how they heard, understood and responded emotionally to what was being said even when health care professionals assumed they were unaware (Lawrence, 1995). Walters (1994), however, described how many ex-patients' memories of communication with nurses in ICUs were negative. These findings were supported by the studies of Haffsteindoffir (1997) and Robinson (1975) who found patients reported feelings of frustration, anger, exhaustion, and hopelessness as a result of nurses' poor communication. Therefore, even though the importance of effective communication in ICUs is well established, it appears that effective communication is not always apparent. What remains unclear in the literature, however, is what nurses perceive as effective communication in ICUs.

AIM OF THE STUDY

The aim of the study was to explore the experience of communicating effectively with patients in an ICU from the nurses' perspective.

RESEARCH METHOD

Research design

A descriptive qualitative study was undertaken in order to explore nurses' perceptions of effective

communication. Stories were utilised as a means of collecting data to aid with this in-depth exploration of nurses' perceptions. Stories, embedded with meanings, are an essential part of understanding of how humans experience their world and relate to one another. Baker and Diekelmann (1994) claim that through a story, the practice of nursing is explored and as a result, new insights into the practice world are revealed. Further, stories, which help people to give meaning to their experiences, have the potential to be a vehicle for reflecting on and transforming professional practice (Abma, 1999).

Participants

The participants were registered nurses who worked in an ICU facility in a regional city in Queensland. At the time of the study, approximately 90 registered nurses were employed in the town. Purposeful sampling, usual in a study such as this one (Burns & Grove, 1997), was used to ensure that the data received would be applicable to the area of interest. Initially senior staff members were approached and the names of staff whom they considered effective communicators with their ICU patients were requested. Although the opinion of colleagues can be considered quite subjective, the authors accepted the senior members' judgements and abilities to assess and identify nurses who were able to achieve patient reassurance through their communication skills. This method of identification of experts by colleagues was also used by Benner, Tanner and Chesla (1996) and Walters (1994). This technique was therefore considered worthy of use in the context of this study. From the nurses recommended by colleagues, 10 in total, one person at a time was randomly selected by drawing a name from a hat. This person was then approached with details of the study and asked if s/he would be interested in participating. This process of participation selection continued until there were four nurses who agreed to participate. The sample size was limited in number for two major reasons. First, the time frame for the research, 10 months, would not accommodate the time required for interviewing and analysing data from a larger participant group. Second, a small number of participants is acceptable in descriptive

qualitative studies such as this one (Burns & Grove, 1997).

Ethical considerations

Ethical approval to conduct the study was granted by the relevant Ethics Review Boards. Interested participants were provided with an information sheet that described the study and data collection processes, and those people who agreed to participate in the study were asked to sign a consent form at the beginning of the first interview. The participants were then reminded of their right to withdraw from the study at any time and their right to refuse to answer any question. All data were stored in accordance with the relevant guidelines. The participants' right to privacy and confidentiality was ensured during the interview process by conducting interviews in private areas. Participants were assured that in the writing up of the thesis and in further publications all effort would be made to protect individual identities.

Data collection

Interviews were conducted in which participants were invited to tell a story about effective communication with a patient in an ICU. Each interview was conducted in an interactive, dialogical manner of the kind described by Campbell and Bunting (1991). The researcher used probing questions to encourage the participants to expand the story or provide related information. Sentences such as: 'I am interested in hearing a story about an incident involving your communication with a critically ill patient', and 'I would like to hear about an incident in which you feel your communication was helpful to your patient' were used to begin the data collection. Probing questions such as: 'Can you tell me more about that?' were used to encourage the participants to expand on their stories. The interviews were approximately 60 minutes' duration and were audio-taped and transcribed verbatim.

Data analysis

In order to generate a meaningful interpretation of the data compiled during the interviews, the stories were analysed using the framework outlined by Emden (1998). This framework involves

a 7-step process in which the data is sequentially 'combed' for keywords and phrases. These being:

1. Read the text as a whole. This is done several times, until a 'feeling' for the key theme(s) of the story emerges.
2. Numerous copies of each transcript are printed; in this study there were six in all, so that key words or sentences can be physically cut out and placed aside.
3. One complete copy of each transcript has every line on every page numbered, and is used as a master copy.
4. Each transcript is then dissected, and key words or sentences are cut out of the copies and placed in mounds or groups of related concepts. Care is taken to ensure that the page and line numbers from the original transcript are recorded on the 'cut-out' so that it can be traced back to the original transcript with ease.
5. The mounds of related themes are examined, with individual 'cut-outs' grouped and regrouped until no further movement of ideas can be made without losing the uniqueness of the theme.
6. The original transcripts are re-read, keeping in mind the key themes and 'core' stories that evolved from the analysis.
7. Once satisfied that the 'core' stories and themes identified match the meaning intended during the initial interview, return to the participants to confirm that they agree with the themes identified.

The second interview, in which participants were presented with the emerging analysis from their story, was utilised to address the issues of trustworthiness and authenticity. Leininger (1994) noted that the very nature of qualitative research delineated it from being subject to the strict rigors of the quantitative parameters of validity and reliability. The parameters of validity and reliability, as used to verify worthiness and merit when applied to qualitative research, are not suitable methods of establishing merit when applied to qualitative research. The researcher turned to the methods used by other qualitative researchers

and proposed that the establishment of credibility and authenticity of the data was a much more useful tool in verifying the worthiness and merit of the data (Usher, 1997).

Two methods of assessment were employed to establish the authenticity and trustworthiness of the study's findings. The first was a personal journal kept throughout the study. In this journal, recorded were thoughts, feelings and attitudes about the interview and data received. This allows the researcher to identify any biases towards the data and the subject as a whole. The second method employed to establish the authenticity and trustworthiness of the data was the second interview with participants. This second interview gave the participants the opportunity to confirm or deny the truthfulness of emerging themes. The participants' confirmation that the interpretations of the data correlated to their expressed intent validates the data's trustworthiness and authenticity.

THE FINDINGS

Communicating effectively with patients in intensive care units is a total experience. There is no one quality or aspect of communication that stands alone as the key to establishing effective communication. The themes that emerged from this study—nurses' perceptions, 'presencing' and reassurance—indicate that these basic components, when combined and used appropriately, result in effective communication.

Nurses' perceptions of quality of communication

From this study, it appears that quality communication is the foundation of effective communication. It involves an attention to the details of sending a message. Simple language and appropriate, sensitive and congruent verbal and non-verbal cues help to ensure that the quality of communication is such that effective communication is established. The participants in the study believed that the use of congruence, empathy and paralanguage cues such as tone of voice and timing impacted positively on how the patients reacted and responded to communication. For example:

I did all the right things, I told him my name, that he was back in intensive care ... But still I could see that he was very upset and agitated ... So I started again, this time, I sat on the bed, I gave him my full attention, I smiled, held his hand, and began again, this time talking slowly and showing him that it was all right, that he was okay. (Sidney)

This participant is speaking about matching the verbal word with non-verbal communications by smiling, getting attention, talking slowly and offering assurance both verbally and non-verbally. The participant was outlining congruence, or a harmony between the verbal and non-verbal aspects of communication. Congruence is a key element in showing the patient that nurses are genuine and sincere in their comforting and helping role.

Empathy for the patient is how this participant described quality of communication with patients:

Anyway, I found that I got on really well with him, only because I empathised with him ... He didn't want all the medications that we shoved down his naso-gastric tube. I understood why he would push me away ... He knew that ultimately it wasn't going to help ... I would like to think that I understood this reaction. (Leslie)

In the critical care setting of an intensive care unit, the use of empathy is no less important than in any other area of nursing. In addition to providing acute nursing care, the critical care nurse must also help the patient cope with the crisis they are currently facing (Bailey, 1996). Without empathy, the nurse decreases personal involvement, and responses appear standard, professional and detached. Morse et al. (1992: 18) go so far as to state: 'Nurses who respond without empathy may appear uncaring, mechanical, and at best, their responses can only be described as "absent-minded kindness".' Reynolds and Scott (2000) claim that the concern with low empathy is that some clients who need to be understood by their nurse might not be and, as a result, receive an unfavorable health outcome.

For another participant, quality of communication involved talking gently and timing communication with patients:

I kinda [sic] told her things gently, so it wasn't straight up flashing in her face ... I told her that we've got some quite bad problems here, and gently eased my way into talking about the really bad stuff. (Sam)

Patients, particularly those in intensive care, are emotionally labile, and the nurse wishing to comfort a distressed or emotionally unstable patient is best advised to employ soothing vocal tones (Stein-Parbury, 1993). This participant also saw timing as a key element of 'how' to communicate. Good timing of communication involves being aware of events preceding and following the interaction. For example, distressing news needs to be given at a time when the patient is best able to receive and cope with the information (Kozier et al., 1995).

For critically ill patients in intensive care units, the non-verbal aspects of communication appeared to have great importance. The participants identified touch and other non-verbal forms of communication as the most powerful, and at times were the only effective means of communicating a commitment to the patient, and a desire to help.

Touch was identified by all the participants as a major form of non-verbal communication:

I went up and started massaging her shoulders, and I could just feel her relaxing ... She didn't need me to tell her to relax, that wouldn't have helped ... Just massaging her was what she needed. (Sam)

Touch was very important to this participant, because the patient was ventilated and unable to respond verbally. Adomat and Killingworth (1994) support the use of touch when words have no meaning, such as when the patient cannot talk. According to Ingham (1989), the effective use of touch in the intensive care unit is of great importance in communicating 'caring' for the patient. This view is shared by McCorckle (1974) who reported that touching critically ill

patients indicates concern for them, and increases the number of positive responses.

For another participant, quality non-verbal communication was attentiveness to the patient:

I stopped what I was doing ... I mean, filling the drip chamber could wait for a minute, couldn't it? (Chris)

Facial expression is another form of non-verbal communication, and one that this participant believed was helpful when communicating with the patient:

I found that smiling always seemed to make her a little more relaxed. Often she would try to smile back at me, or squeeze my hand. After, when she was not ventilated, she told me that it was my 'cheeky smile' and winks that made her day. (Chris)

Facial expressions are an outward, visible indication of a nurse's feelings and emotions toward the patient. However, cheerfulness and overt friendliness must be tempered with an understanding of the patient and his/her current emotional state. As this participant pointed out:

Humour really helped, but I had to be tactful and mindful of the situation. You know laughing and smiling when she was really upset just did not feel right ... There were times that I knew a joke would help and times when I knew that she just needed me to shut up. (Sam)

This participant's narrative highlights the need for nurses to be in tune with the patient's emotional and physical status. Stein-Parbury (1993) advises that each type of response has a different intent, and will therefore have a different impact on the interaction. Timing and awareness of each type of response is crucial in developing effective communication (Cormier et al., 1986).

Another important aspect of quality communication identified in the study was the need for communication to be simple and free from confusing technical jargon:

He just looked at me, really confused and

scared. At that moment it hit me; it just blew me away to realise that even after my big long speech the night before, he hadn't comprehended a thing that I had told him. (Sidney)

Explanations, although very important, must be given in a form that does not 'lose' the patient in the way described above. Nurses frequently fall into the trap of lapsing into prolonged speeches about the procedure or the immediate environment, while failing to observe how little the patient comprehends. Fareed (1996) contends that explanations should not contain so much detail that they will confuse the patient. Clear, concise explanations from the nurse are required by patients, without all the technical jargon.

The use of jargon when communicating with patients is fraught with the danger of being anything other than helpful to the patient. Effective communication promotes interaction and understanding between the nurse and the patient, but professional jargon is often only understood by those in the profession, so why should we expect our patients to understand it? Jargon serves to confuse the patient, can lead to misunderstandings about explanations, and ultimately can leave the patient feeling quite demoralised (Cormier et al., 1986). Nurses are caught up in the professional realm of medicine, and the use of complex medical terms and jargon comes naturally. However, these terms often have no meaning for the layperson and can cause confusion. Simplicity fosters helpful communication with the patient, because the patient is able to understand the nurse and the content of the message. Walters (1994) contends that plain talk, or the use of simple narrative, is a way that nurses might comfort and allay the fears of the critically ill patient, thus possibly initiating and fostering communication that is helpful.

Presencing

Presencing was the next major theme identified in the study. This theme was evident in each of the participants' stories. The Heideggerian concept of 'presencing' has been used by nurses (e.g. Benner (1984), Hayes (1997)) to describe the

availability of the nurse to the patient, by a process of human relating. In other words, to presence oneself with another means that one is available to understand and be with another (Heidegger, 1962). Presencing involves situating of the nurse's self sensitively and imaginatively in the world of those being cared for (Benner, 1984). Not seen until focused upon, presencing involves the total commitment of the nurse. The immersion of the nurse—body, mind and spirit—in the art of communicating effectively with patients, sends the silent yet powerful message: 'I understand, I care, and I am here for you.' Presencing, the gift of the self, is a display of genuine and honest acceptance of the patient, and the patient's world and experiences.

The participants identified sharing being human with the patients, self-disclosure and use of the body to physically presence; and the intangible yet manifest 'knowing' and 'sensing' the needs of the patient were evident in all the narratives. The nurses in this study appeared to share a view that presencing is the soul of nursing, the spirit of caring and the embodiment of nursing as a caring and helpful profession. This study, although limited, appeared to support the value and strength of presencing, and its importance to effective communication.

There are many ways of describing and exploring this concept of presencing. One participant spoke of the concepts, 'sensing' and 'knowing', which have been interpreted in this study as a form of presencing:

I mean, even if she didn't hear anything that I was saying, I was still right there, and I would like to think that she could sense that I was there ... She wasn't without any ability to sense, something of my presence must have got through to her. (Chris)

In speaking of the patient's sense that the nurse was there, this participant identifies a theme that was evident in each of the stories. All participants spoke of the patient sensing that the nurse cared, and similarly, the participants spoke of sensing what their patients needed. This participant describes another aspect of presencing similar to this concept of sensing as knowing:

When he finally lapsed into unconsciousness, I just knew, felt, that I was still reaching him, somewhere deep down inside that unconscious state he knew I was there for him, still helping him to cope. (Leslie)

These two vignettes from the participants' stories indicated that the nurses believed their patients sensed the nurse's presence without verbal communication. This concept of sensing and knowing were very real to the nurses in the study, and yet they are aspects of nursing that cannot be measured or quantified. They are governed by the soul and nurse's desire to immerse him or herself into the patient's life world. In doing so, the nurse comes to know the patient, and through this knowing is able to provide the care and support needed without being directed by verbal requests.

Milne and McWilliam (1996) believed that presencing involves sharing humanness, and that sharing humanness involves some self-disclosure on the nurse's part. Through self-disclosure and the sharing of emotions, the person, not just the nurse, is revealed. The patient is allowed to see beyond the uniform and the professional mannerisms, to see that the nurse is just as human as s/he is.

Benner and Wrubel (1989) spoke of shared humanity in their description of presencing. This sharing of humanness, of being an ordinary person, was evident in the participants' narratives:

I don't really think that I can describe how I felt. I guess I sort of felt uncomfortable talking to her ... I told her how uncomfortable I had felt. (Chris)

This participant describes feeling uncomfortable talking to a ventilated and sedated patient. However, the participant goes on to say that those personal feelings and emotions were eventually shared with the patient and, through this sharing of personal information, the participant believed a strong helpful relationship developed.

A further concept of presencing is a silent presencing, described by one participant as:

I noticed those shoulders going up and I went

over and started massaging ... She didn't need me to tell her to relax ... I found that massaging her was what she needed. (Sam)

In this vignette we see that presencing does not necessarily require verbal communication. The simple act of touching and responding to the non-verbal cues of the patient, the participants believed sent the message: 'I am here to help.' Joel (1997) refers to this silent presencing as a message of acceptance. The nurse, through silent, yet purposeful bodily presencing, receives and responds to the emotional state, and assures the patient that his/her emotions are not too extreme. Gardner (1985) describes presencing simply as the gift of the self. Nelms (1996) reported that the subtle use of touch is a potent and effective way of communicating and connecting with patients. From the participants' narratives, it is possible to consider that nurses' silent communication and presence might signify a depth of understanding and caring that words could not so easily convey.

Reassurance

The final theme to emerge from the data was reassurance. Building trust, giving information and caring, the subthemes of reassurance, are the culmination of all that has gone before. Effective communication has been achieved when the patient feels reassured. Simple, honest, genuine communication, together with the nurses' physical and spiritual presence, appears to create an atmosphere of trust and security for patients. The nurses' stories indicated they felt their attempts at effective communication were reassuring to their patients. In this study, reassurance appeared to be pivotal to all aspects of communication. It appeared to be part of the other two themes and yet substantial enough to stand alone as a significant theme of effective communication.

Although reassurance cannot be described as empathy, it requires an empathetic orientation to patient care (Fareed, 1996). Furthermore, the act of reassurance is not merely confined to the use of verbal communication, but must encompass all aspects of nursing, from physical contact with the patient through to the nurse's body language. The

participants' narratives indicated that the reassurance of patients entailed the formation of a trusting relationship, the giving of information and, of course, caring on the part of the nurse.

Trust is an essential component in establishing helpful communication with patients. Trust allows the nurse-patient relationship to progress beyond the superficial level. Within a trusting relationship, confidence is fostered by the nurse's capacity to be accepting, supportive and sensitive to the patient's needs (Stein-Parbury, 1993). One of the most basic components in building trust within a relationship is honesty. Stein-Parbury (1993) reported that nurses must at all times live up to the patient's expectations that the nurse can be trusted. This view is shared by Cormier et al. (1986), who state that the nurse must be viewed as a reliable and credible source of information. Accurate, reliable and honest information will enhance the trusting relationship:

I would tell her everything is okay, you're doing really well ... She trusted me, she knew I wouldn't tell her it was okay if it wasn't ... We had been through some rocky patches, and I had been honest with her, and told her that things weren't too good at the moment. (Sam)

As can be seen in this participant's story, the patient and nurse had a relationship based on trust.

A further view on establishing a trusting relationship is offered by Fareed (1996), who contends that a trusting relationship is established when nurses approach patients with certain decorum. To develop trust in the nurse-patient relationship, it is vital that the nurse maintains professional decorum. Respecting the patient's right to privacy and confidentiality, especially when dealing with information and aspects of patient care that might be of an embarrassing or sensitive nature, is essential if a relationship of trust is to develop. Cormier et al. (1986: 39) advise that it is the nurse's duty to maintain patient confidentiality. They further state: 'Nothing will destroy trust more quickly than a patient's discovery that confidential information has been shared inappropriately.'

A third component of establishing a trusting relationship is advocacy, as this narrative describes:

He didn't want all the medications that we shoved down his tube ... He would push us away when we tried to give them, he knew ultimately it wasn't going to help ... I managed to get a lot of them stopped. (Leslie)

This participant advocated for this patient's right to have active interventions withdrawn, and this act of advocacy might have earned the participant the patients respect and trust.

Reassurance, however, is not achieved by simply establishing a trusting relationship alone. A second major component of being reassured has been described as the elimination of not only fear of the known but also fear of the unknown. This is accomplished by giving accurate information about details of treatment, the nature of the patient's condition, and receiving explanations about the many sights, sounds and smells that the patient is encountering.

One participant believed that giving information was reassuring for patients:

I went on to explain everything else about the unit around him, the noises that he could hear and what they meant. (Sidney)

Giving information about the environment around the patient may provide reassurance by giving the patient some understanding and control over his/her environment. With reference to the intensive care setting, White (1972) suggested that patients' psychological needs will be met and reassurance given, if patients are kept fully informed.

Fareed (1996) suggested that patients also feel reassured when they are well cared for, or when nurses showed that they were caring. Caring attributes have been identified as including caring for, caring about, and being supportive and showing concern. The nursing skill portrayed in this study's narrative was not in managing the technology of the unit, nor the administration of the many medications. These task-oriented skills were not recalled as caring time. Caring, for

these participants, was linked to all the other themes previously identified. Caring embraces empathy, presencing, touch and the gift of the self. Nelms (1996: 368) offers this description of the essence of caring: 'Caring makes you understand richer and deeper. All of the mechanical scientific technology may save lives, but it doesn't create caring bonds. Caring does.'

When reflecting on this concept of reassurance, what became clear from the narratives was that, although standing alone as a theme of effective communication, reassurance also in many ways embodied much of what the other major themes discussed. Reassurance is the outcome of the nurses' use of empathy, presencing and touch. Reassurance is also given by way of information, as described in quality of communication. This understanding endorses Gregg's (1955) assertion that reassurance involves all aspects of nursing.

REFLECTION ON THE FINDINGS

When reflecting upon the narratives, and the identified themes, something quite unexpected emerged. Previous research had identified communication as less significant than task orientation and knowledge base for critical care nurses. In contrast, this study revealed how nurses perceived effective communication as a very important and fundamental aspect of caring for patients in intensive care units. Perhaps this research finding is related to the fact that communicating is considered such an 'ordinary' and fundamental skill. In other words, communicating effectively in an ICU is considered just part of a nurse's 'ordinary' tasks. However, the narratives in this study support the notion that effective communication is the base for all that these nurses have to offer and value in nursing people in ICU.

Contrary to the research undertaken from the patient's perspective, these participants suggest that patients will respond positively and will be comforted and reassured when the nurse employs effective communication. This is an important finding in this study, where we are not only led to challenge the idea of nurses as effective communicators, and 'ordinary', but also that effective communication is both necessary to the

ICU setting and also an aspect of the 'ordinary' side of ICU nursing care.

FUTURE RESEARCH

The ordinariness of things that we do everyday, such as communicating effectively, in fact is very important and deserves to be unravelled. However, communicating effectively appears to be a complex concept and as such warrants further investigation. The findings of this study revealed that the nurses believed they did communicate helpfully, although the literature from the patients' perspective suggests otherwise. Therefore, research that focuses on the patients' understanding of what constitutes effective nurse communication is needed to help clarify the findings of this study. A model of nurse-patient interaction that explores if 'what is perceived' is actually 'what is received' is also considered a worthwhile possibility for future research.

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