

Being Voiceless: A Review On Patient Communication In Intensive Care Unit

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ABSTRACT

Introduction: When speech is integral, the interactions will come out automatically; but if the speech is damaged, even the necessary conversation is challenging to handle. While providing nursing care to the patients, nurses must appreciate the uniqueness of each patient and try to promote good health and well-being as much as they can. To do so, the nurses must help the patients to fulfil their needs by adequately listening to the patients' 'voices'.

Objective: To appraise available evidence that investigates voiceless among patients in the Intensive Care Unit.

Design: A literature review.

Data sources: Six online databases namely CINAHL, ProQuest, ScienceDirect, Clinical key, Scopus, and Ovid Medline were searched.

Review methods: Relevant studies were identified using the combined approaches of electronic database search and manually searched journals.

Results: Twelve 12 studies met the inclusion criteria. A few topics summarised from the studies provided a general view of the nurse-patient communication in the Intensive Care Unit, barriers and factors that limit the nurse-patient communication, consequences of voicelessness, and the methods to overcome voicelessness.

Conclusion: Supports from nurses are needed by patients, especially when they are mechanically ventilated, for them to make sense of their conditions and to try to cope with it.

Keywords: being voiceless, nurse-patient communication, interaction, intensive care unit, ICU's patient, ICU nurses

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INTRODUCTION

Communication is an essential element in our life as human beings. Not able to communicate effectively will pose a significant impact on our physical or mental well-being. The scenarios become worst if someone is unable to communicate verbally when his/her health condition does not permit them to do so. When the voice of the patient cannot be understood, their needs may not meet their expectations. Schandl, Falk, and Frank (1) stated that nurse-patient communication could occur through facial expression and negotiation through dialogues, which give opportunities for the patient to get involved in their care by providing their opinions through verbal or non-verbal communication.

However, in some cases, contextual factors cause the nurses to prioritise other tasks before being able to communicate and assist the patients (1). It may occur in a scenario where the critically ill patient is unable to communicate effectively and convey their needs, which in most cases transpire in the ICU. Been hospitalised is already stressful to certain people, and it became more stressful when they are admitted to the ICU where the possibility of being connected to a mechanical ventilator is high. Mechanically ventilated patients commonly have a problem to communicate and convey their needs (2) since they will become voiceless for a certain period this would lead to psychological distress (3). Being voiceless will further burden the patients physically or mentally and also cause distress to the people around them. A study by Tembo, Higgins & Parker (4) found that patients with a mechanical ventilator showed signs of distress due to ineffective communication with their family and the medical staffs.

When someone falls sick, being voiceless might be a hard thing to cope with, and thus worsen the state of their health. Nurses in ICU faced a significant challenge to communicate with a mechanically ventilated patient, and it occurs because of specific barriers that limit the effectiveness of communication between these two groups. Additionally, patients may think that the medical staff are busy with their work and did not have time to listen to their needs (2, 5). Nurse, on the other hand, tend to communicate less while doing bedside care if the patients are not fully conscious (6). In other words, an interaction period that is too short and revolve around the job-related conversation might contribute to a negative feeling to the patients.

Mechanically ventilated patients have difficulties conveying their feelings and perception, and they also need to cope with fears, anxiety, and stress while not being able to verbalise their needs (7). Various factors contribute to the voicelessness or ineffectiveness of communication in the ICU environment. Happ (2) revealed that often ICU nurses' hands are full with their work, and they hardly understand the patients' cues, and patients are unable to write are some of the factors that disrupt nurse-patient communication. Furthermore, patient's conditions and intubation period are the other factors that give impact on the effort to communicate between the nurses and patients (6). A study by Epstein et al. (8) listed factors that influence patient-centred communication which include a) patient factors - the severity of illness; b) health system factors - environment, devices to communicate; c) relationship factors - trust issue, duration of the relationship; d) clinician factors - personality, knowledge of the staff.

Ineffective communication or not being able to vocalise their own needs might result in negative consequences, especially for the patients. The repercussions from the voicelessness include frustration, anxiety, powerlessness, loss of control, and restlessness for the patients because they no longer feel the sense of freedom (9-10). When someone's independence and ability to communicate are neglected, or their expectations are not met, they already lost from the battle to stand up for their rights. In other words, difficulties in communication might lead to aggression, feeling hopeless, loss of control, feeling of uncertainty, anger, fear, feeling objectified, frustration, loneliness, and heightened the sense of death (4).

Various methods had been mentioned in previous studies to close the gap of communication between medical staffs and patients in ICU. Different strategies led to the possibility of improving the patient's condition, but they are quite challenging to be implemented mainly in the clinical setting (11). The methods include the using of communication assistive devices such as charts, boards, writing pads, or using high-tech devices (12). Other than that, establishing rapport and taking time to learn how to interpret the message from a voiceless patient would help communication become more active (9). Karlsson, Forsberg, and Bergbom (9) observed, interpreted and described nurse-patient communication in ICU revealed that nurses unconsciously using various ways to communicate. The useful methods are using eyes contact, vocal intonations, body gestures, and also touching. However, Karlsson, Forsberg, and Bergbom (9) revealed that some of the nurses did put some distance which makes patients felt reluctant to communicate, and they thought that their voices meant nothing and did not count as necessary to the nurses.

This paper provides a review of previous studies regarding the phenomenon of interest. The review covers the concepts that occur including 1) the general view of nurse-patient communication in the Intensive Care Unit, 2) barriers and factors that limit nurse-patient communication, 3) consequences of voicelessness, and 4) methods to overcome voicelessness.

MATERIALS AND METHODS

The search strategy was conducted using online databases for medical, health care, and social sciences to find articles related to the issue of voicelessness. The databases are CINAHL, ProQuest, ScienceDirect, Clinical key, Scopus, and Ovid Medline. Keywords used to search the information included 'voicelessness', 'being voiceless', 'nurse-patient communication', 'non-vocal', 'speak', 'silent', interaction, which were then linked to 'intensive care unit', 'ICU's patient', 'ICU nurses' to capture related articles reporting on voicelessness among patients in ICU. The search strategy conducted prioritised studies published from the year 2005 to the current year, and all full texts containing original research articles [such as scientific experiments, surveys, and research studies] and review articles were included. While narrowing down the scope, the inclusion and exclusion criteria have been set before the literature search to uphold the focus of the review. The inclusion criteria for searching the literature are 1) studies on adult patients [18 years old and above], 2) studies published in English or Malay languages, 3) match with the keywords, 4) studies published from the year 2005, and 5) full-text articles. Articles or studies that focus on patients with Tracheostomy and unstable condition were excluded.

The study selection was conducted in three stages: 1) the initial screening of titles, 2) removal of studies based on duplication, inclusion and exclusion criteria, and irrelevant titles, and 3) the screening of the abstract against the inclusion and exclusion criteria followed by the selection of the full papers identified as possibly relevant to the review objectives and questions. The initial search reveals 3217 articles altogether. After screening the titles and removal of duplications, 38 articles passed through second stages for abstract and full-text screening if the abstract was not clear enough to identify the inclusion and exclusion criteria for review. Next, only 12 articles were retained based on the inclusion and exclusion criteria [Figure 1].

Critical appraisal of the selected studies were carried out to appraise and describe the methodology quality of the reviews. The selected studies were methodologically varied; thus, the researcher used guideline from Joanna Brigs Institute (13) for the systematic review [JBI critical appraisal checklist for systematic reviews and research syntheses] and case study [JBI critical appraisal checklist for case reports], and the appraisal tool developed by Hawker et al. (14) for other selected studies as a tool to appraise the selected studies. In summary, the quality of the selected studies was good. Several minor weaknesses did not misrepresent the quality of the studies. The content of the studies provides adequate information about the topic of interest.

To aid better understanding of this phenomenon, a few topics were summarised from the literature as follows:

1. General views of the nurse-patient communication in the Intensive Care Unit
2. Barriers and factors that limit the nurse-patient communication
3. Consequences of voicelessness
4. Method to overcome voicelessness

DISCUSSIONS

Twelve studies had been reviewed and used for discussion in this paper. The 12 studies are listed in Table I.

1. General view of nurse-patient communication in the Intensive Care Unit

Communication never stays static, and it moves along between satisfaction and dissatisfaction, depends on how someone handles it (15). When speech is integral, the interactions will come out automatically; but if the speech is damaged, even basic conversation seems challenging. As a nurse in ICU, while providing nursing care to the patients, nurses must appreciate the uniqueness of each patient and try to promote health and well-being as much as they can. To do so, the nurses must help the patient to fulfil their needs as maximum as they can. The best way to provide appropriate care, based on the patient's need, is by properly listening to the patient 'voice'.

However, most of the patients in ICU are unable to voice out loud their needs due to the presence of the endotracheal tube (ETT). The features of ETT that have a cuff that obstructs the larynx and also the airflow render the mechanically ventilated patient with no choice but to live temporarily in a voiceless state. There is another reason that limited the patient in ICU from communicating vocally, including medical interventions such as mechanical ventilation (16-17), patient's conditions such as respiratory problem, neuromuscular weakness, fatigue (17), and also cognitive deficits (18).

Unable to speak is like being trapped in a silent world, and everything seems slow. Being voiceless is not a choice for the mechanically ventilated patients, and to them, it was as if their body functions were taken away from them against their will. Due to the complexity of their conditions while being admitted and treated in ICU, the voicelessness may interfere with the expression of their needs including pain, fear and similar emotions. It resulted in them struggling just to deliver their messages to others.

2. Barrier and factor that limits nurse-patient communication

Since the 1980s, a study investigating the problem of nurse-patient communication revealed that when a patient is unable to give respond, his/her interaction becomes minimal and the conversation between the nurses and patient is more task-oriented and centred on explanation about what the nurses will do to the patient (19). Talking with voiceless patients is like playing a guessing game which resulted in either being correct or misinterpreting their message (15), which later on will lead to satisfaction or dissatisfaction for the nurses and especially the patient. The barriers and factors that limit nurse-patient communication in ICU vary, and the severity depends on how someone perceived it. The nurses listed the patient's mental state, time, and knowledge of the best communication method with the patient (20) as the primary barriers that hinder them from communicating effectively.

To minimise the barriers and to improve the communication with a mechanically ventilated patients, a health care provider needs to: a) be knowledgeable and skilful, b) have suitable supporting material or equipment, c) have appropriate strategies (20). Nurses need to be more interactive while keeping in mind that each individual has his/her own needs and communication is a basic need of a human being. Somehow, the attitudes of the nurses such as being 'inattentive' often lead to the increase in the level of anxiety, worries, and fears among the patients, which may defeat the possibility of building trust among them (9). The other ways to minimise the barrier in communication are by selecting appropriate methods of communication so that both parties [nurses and patients] might get benefit from it. For an example, choosing the communication board as the medium for communication is effective if the patients are mentally stable, have no problem with their sight, and able to read and write (21).

Unfortunately, some of the nurses tend to keep their distance which caused them to unable to see the efforts to communicate showed by their patients (9). Nurses claimed that time, patient's conditions and lack of training are the factors that constraint their communication with the patients (20). Consequently, the nurses will lose opportunities to talk and gather information from the patient. Gathering information from the patients is an essential element that helps in shaping the nursing care plan, which suits a particular patient and situation.

In conclusion, the nurse-patient interaction in the ICU can be optimised by eliminating the factors that contribute to the futility in communication. However, to entirely remove the barriers and factors that limit the conversations are not an easy task and needs some effort from the nurses and also from patients. The nurses must bear in mind that the way they handle the barriers and

factors to communicate might end with a good or bad consequences.

3. Consequences of voicelessness

According to Radtke, Tate & Happ (20), there are several consequences of voicelessness. Firstly, nurses reported that ineffective communication together with stressors faced by patient lead to the late recovery from critical illness and prolonged the hospital stay. Secondly, ineffective nurse-patient communication happens due to the misinterpretation of messages or the message was ignored. Thirdly, the selection of an appropriate methods to communicate is perceived as saving time and valid for patients who have limitation in communicating without their voices and finally, the strategies or trends that seen as effective tend to be followed by others. Nurses need to find effective ways to minimise the consequences that might be experienced by the patients and might also give impact to the nurses' work. Patak et al. (17) also recommended that health care provider enhance their method for assessing, evaluating, and monitoring their communication with the patients by capturing the exact meaning in each of the conversations. By doing so, it might help the nurse to plan the appropriate nursing care for the specific patients.

Being voiceless, to patients, gives a significant impact on their lives since their basic needs are taken away. A study by Patak et al. (7) reported a high level of frustrations among patient [62%, n = 18] when they were unable to communicate effectively while being ventilated, 24% [n = 7] reported frustrations or being somewhat frustrated, and only 14% [n = 4] said they were not frustrated. It indicates that become voiceless can cause frustrations, anxiety, fear, helpless, panic and also demotivation especially among critically ill patients (17-18). The risk of suffering negative consequences from being unable to speak is higher among ICU patients when they do not just become voicelessness, but sometimes the conveyed message has been misinterpreted by the health care providers. It may lead to frustrations, and they may give up trying to communicate since others cannot understand their 'voice.'

Due to the inability to speak, the patient might experience the delay in the treatment and adverse medical effects (16, 18). When the patient becomes voiceless, their actual needs become unclear to others which might interfere with the nursing care plan or the treatment plans for them. Furthermore, voicelessness limited the patient's abilities to express their thoughts, feelings, and needs (16). Communication problem faced by the patient in ICU give impact on them either physically or mentally and also affected their quality of care (16, 18). Holm and Dreyer (15) listed and explained the negative consequences as:

- Frustration, when the patients become unsatisfied with the nurses' interpretations, they become frustrated and give up communicating even more.
- A communication failure may lead to the feeling of helpless, sad, angry, lonely, humiliation and trapped.
- Nurses who face the challenge of interpreting become frustrated when they are unable to do so correctly, and they might give up interacting with the patient.
- By being voiceless, the patient felt powerless, while the nurses gain the authority to decide on when to communicate and what topic they should choose to talk about with the patients.

However, positive consequences can be achieved when the nurses are able to correctly interpret the messages from the patient (15). The advantages of communication assistive materials or devices are they might help nurse-patient communication, decrease the frustration, and help in identifying patient's needs faster compared to do nothing (21).

4. Method to overcome voicelessness

Communication with mechanically ventilated patient varies from the purest facial expression or body gesture to the use of high-tech devices. Moreover, the critically ill patient tends to use the most straightforward nonverbal communication such as gestures, head nods as their way to communicate (2, 22). However, health care provider sometimes tends to limit the question which has yes or no responses which may not convey the exact message from the patient (17). Despite it, nurses are described as the best mediator needed by the critically ill patients to deliver their message to someone else or seeking help from nurses, since nurses are the closest person to the patients in ICU (20).

A systematic review by Ten Hoorn et al. (21) listed four interventions to help in communicating with the ventilated patient, which are communication board, speaking valve, electrolarynx, and high technology Augmentative and Alternative Communication [AAC]. Furthermore, the AAC devices, methods used to communicate, and strategies to improve the quality of conversation should be considered to improve the healthcare services, as proven by previous studies stating the listed activities have the potential to eliminate the communication barrier between the healthcare providers and patients (17). Practically, most of the healthcare providers implemented AAC, which they claimed helps them to communicate better and save their time when dealing with the problem of the lack of skill or tools when dealing with patients in a critical care area, especially for those with a problem to communicate (20).

Report from ten Hoorns et al. (21) suggested that most of the communication materials or instruments may be effective in enhancing communication between health care providers and mechanically ventilated patients. The result of a patient's successful communication depends on what type of materials the nurses use to communicate with them. For example, the communication boards help in improving patient's communication and satisfaction; using high technology AAC proved to be effective communication methods (21). Patak et al. (17) revealed that 97% of their participant responses about communication board help them to communicate effectively while being ventilated. Hence, it can deduced that the method used to communicate with or by mechanically ventilated patients varies depending on the creativity of the medical staffs and also the condition of the patients. By modifying the ways to interact with patients, it not just can help nurses to form an appropriate nursing care plan, but also can assist patients in adjusting with their health condition.

A study by Patak et al. (7) revealed the perception of the patient on intervention with communication applied by health care providers are impactful. Healthcare providers need to intervene on behalf of the patient who is mechanically ventilated as a way to promote communication. The characteristics and attribution of the medical staff have a significant impact on the patient's effort to communicate and also influence the patient's feeling of being misunderstood, humiliated, and dispirited.

To ensure the effective communication between nurses and patients, nurses must be able to build rapport with the patient, able to interpret and be a good listener, and show inattentive attitude when communicating with the patient (9).

According to Radtke et al. (18), the use of AAC gives a positive result especially in communication, weaning patients off the ventilator, assessing the patient's symptom and providing appropriate treatment, and also the discharge rate. Nurses may choose which material is suitable for them to use to communicate effectively with their patients. In some instances, low-tech AAC can be highly effective and cheaper compared to high-tech AAC (18). However, nurses need to beware of their attitudes, body gestures, words selection and also the vocal tones when communicating, so that it can help the patient to calm down and ease their mind.

According to ten Hoorn et al. (21), there are few ways that can be used to maintain effective communication with mechanically ventilated patients, which are 1) clearly defined the communication strategy in the protocol, 2) equipped the ICU with various communication materials and devices, 3) provide training for the health care providers, 4) the successfulness of communication interventions are documented inside the patient's chart.

However, due to the unique condition of the mechanically ventilated patients, specific strategies are not suitable to be applied due to various reasons such as being time-consuming and also the severity of illness. Moreover, some limitation could hinder the nurse-patient communication. Hence, this study aims to explore the practice of the nurses in ICU to communicate with mechanically ventilated patients in the local setting. Other than that, the researcher also aims to explore the barriers and factors that limit the interaction and the possible intervention that can be done from the perspective of the nurses and patients.

CONCLUSIONS

In ICU, the possibility for the patient to participate in their healthcare not only depends on their health conditions but also depends on how far the nurses are willing to include them in their daily nursing care despite the patient's limitation. Literature provided evidence that mechanically ventilated patients perceived that voicelessness affects their well-being. The critical element in communication with mechanically ventilated patients is understanding or being tolerable. To enhance the patient's participation in ICU activities, nurse-patient communication is one of the essential elements to do so. Effective communication not help patients gain their self-esteem, but also can assist nurses in doing their daily nursing care without having conflicts or misunderstandings.

Rapid changes, especially in the patient's health status among mechanically ventilated patients in the ICU make the nurse-patient communication more complex (15). Hence, ICU nurses need to be cautious and keep on adjusting their ways of communicating with the patient, and this will result in them getting the correct information which eases their task. To do so, nurses need to know the right methods and barriers which may occur during their interaction with the patients. The intervention with communication materials or devices may assist effective communication, but the patient's well-being and emotion positively contributed to the process as well (21). Besides, supports from nurses are

required by the mechanically ventilated patient for them to make sense of their condition and to try to cope with it. Additionally, if the nurses can understand the voiceless ventilated patients' experience, they might come with an effective communication strategy and by making the patient involved in daily nursing care which might help the patient gain confidence. However, the patient might be faced with a slow recovery and emotional disturbances when the nurses cannot understand the patient's voicelessness experiences.

ACKNOWLEDGEMENT

Sincere thanks to International Islamic University Malaysia (IIUM) for funding this publication project (RIGS16-281-0445). There is no conflict of interests among authors and the funder for this project.

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Table I Selected papers for review

Being Voiceless: A Review On Patient Communication In Intensive Care Unit

Authors/ Year	Title
Karlsson, Forsberg, & Bergbom (2012)	Communication when the patient is conscious during respirator treatment: A hermeneutic observation study
Radtke, Tate, & Happ (2012)	Nurses' perceptions of communication training in the ICU
Happ (2000)	Interpretation of non-vocal behaviour and the meaning of voicelessness in critical care
Finke, Light, & Kitko (2008)	A systematic review of the effectiveness of nurse communication with patients with complex communication needs with a focus on the use of augmentative and alternative communication
Patak et al. (2004)	Patients' reports of health care practitioner interventions that are related to communication during mechanical ventilation
Radtke, Baumann, Garrett, & Happ (2011)	Listening to the voiceless patient: Case reports in assisted communication in the intensive care unit
Schandl, Falk, & Frank (2017)	Patient participation in the intensive care unit
Happ et al. (2011)	Nurse-patient communication interaction interactions in the intensive care unit
Khalaila et al. (2011)	Communication difficulties and psych emotional distress in patients receiving mechanical ventilation
Holm & Dreyer (2017)	Nurse-patient communication within the context of non-sedated mechanical ventilation: A hermeneutic-phenomenological study
Patak et al. (2006)	Communication boards in critical care: patients' views
ten Hoorn et al. (2016)	Communicating with conscious and mechanically ventilated critically ill patients: a systematic review