



Lip-Reading Translating for Non-Vocal Ventilated Patients

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Most people use speech as a primary way of expressing themselves, but this option is taken away for many who are mechanically ventilated. The tracheostomy or endotracheal tube interferes with air coming into contact with the larynx, thus impeding speech (Drayton-Hargrove & Mandzak-McCarron, 1987). As a result, patients who are non-vocal due to mechanical ventilation have reported communication difficulties and negative emotions (Frace, 1982; Gries & Fernsler, 1988; Hafsteindottir, 1996; Johnson & Sexton, 1990; Schumann, 1999). Various augmentative and alternative communication (AAC) strategies are employed to assist these patients. Examples are mouthing words, communication/alphabet boards, writing, and body language including gestures (Albarran, 1991; Helfrich-Miller, 1999). Even when these strategies are used, however, communication may remain problematic. A service that can help these patients be understood is lip-reading translating, a term coined by the author.

Lip-reading translation (LRT) is a process whereby a proficient lip-reader determines what a non-vocal patient is mouthing and then verbalizes the patient's statement verbatim to healthcare staff members or family. For example, if the non-vocal patient mouths "I want pain medication," the LRT would say "I want pain medication" out loud so the patient's words can be heard by others who are present. LRT is more easily done when the patient is intubated via a tracheostomy rather than an endotracheal tube because the patient's lips are unimpeded. Most ventilated patients who are alert enough to be able to speak have tracheostomies. The author has provided LRT as an independent consultant at various facilities in Massachusetts, resulting in an overwhelmingly positive response from patients. LRT services also allow non-vocal patients' healthcare providers to spend more time providing patient-centered care, and less time attempting to decipher patients' messages.

Purpose

This paper introduces the concept of lip-reading translation and proposes that this service can be an effective means to enhance communication and thus reduce negative emotions in non-vocal patients. Anecdotes from the author's practice will illustrate the usefulness of this service. Healthcare professionals with hearing loss are suggested as ideal candidates to be LRTs.

Communication

Effective communication has been identified as being reciprocal in nature (Hemsley et al., 2001) and dependent on feedback (Simonds, 1995). In healthcare where complex information replete with medical jargon is often given to patients, feedback is essential to reduce uncertainty. Patients have differing education and language levels that require various levels of clarification. Gaining clarification or feedback from a non-vocal individual, however, is difficult because it may not be possible to determine whether the message is received as intended. Despite the documented benefits of open-ended questions over closed-ended questions (MacLeod Clark, 1981), it may be more difficult to elicit information from non-vocal patients using open-ended questions because of healthcare providers' difficulty in understanding the patient's response (Lucas et al., 1988).

LRT: Enhancing Communication

AAC strategies can aid in the communication process. However, they are generally slower than using and interpreting speech (Jones, 1986). Lip-reading translating is faster than most AAC strategies and it offers a way to interpret speech with only a slight delay. An expert lip-reader should be able to understand, usually on the first attempt, what the non-vocal patient is mouthing. The translator then repeats the patient's words immediately after they are mouthed. Non-vocal patients may find mouthing words to be the least difficult method of communicating. It generally requires less energy than writing and is less tedious than an alphabet board, for example. Facial expressions can be used when mouthing words in order to

convey emphasis. Through LRT, non-vocal patients' messages would be less likely to be misunderstood and their needs would be more likely to be met.

LRT: Aiding in Clarification

Non-vocal patients may be misunderstood by healthcare staff and family, particularly if mouthing words is their only means of communication. The author provided LRT for a non-vocal ventilated patient who also had quadriplegia as a result of a motor vehicle accident. For days, this woman had been mouthing something that no one could understand, and she was becoming increasingly agitated as a result. The woman had been asking "Is my son dead?" She thought that her son had been killed in their car accident. The staff and her family had misunderstood what she was saying and they were not providing her with an answer to her question. This misunderstanding was quickly clarified through LRT, and the patient was visibly relieved when she learned from her family that her son was fine.

Gestures have been identified as the method of communication used most often among non-vocal ventilated patients (Happ, 2001). These gestures, however, can be misinterpreted as anxiety (Jablonski, 1994) when in reality the patient may be simply attempting to convey a message and be understood. If a patient appears anxious, healthcare providers may administer a sedative (de Toledo, 1980; Hansen-Flaschen, 1994; Jablonski, 1994) or apply a restraint (Frace, 1982). Sedatives can further suppress respiratory drive (Manthous, Schmidt, & Hall, 1998) and restraints can further increase agitation (Frace, 1982). Effective communication, facilitated with LRT, could lead to more appropriate assessments of anxiety so that the best intervention could be used.

Informed consent and autonomy are two main ethical principles that need to be followed to ensure that the non-vocal patient can be involved in his/ her own care (Purtillo, 1986). Patients need to be able to give true informed consent and be able to make decisions about their own care (Belitz, 1983; Dracup & Raffin, 1989; Oppenheimer, 1993). The American Thoracic Society (1991) identified the ability to communicate as an important factor in determining patient autonomy in difficult end-of-life situations. Autonomy is also an essential principle of the weaning process (Pierce, 1995). Miscommunications clearly must be avoided when such issues involving autonomy and informed consent arise. It is imperative that patients' responses be understood with accuracy, and it is helpful if the non-vocal individuals do not have to mouth their sometimes very difficult decisions repeatedly in order to be understood. The author has assisted patients and families and healthcare providers with discussions of this nature. All parties have reported feeling reassured that the patient's wishes were fully understood. After all, a mistake in understanding a non-vocal patient when discussing such important matters could have catastrophic results.

LRT: Helping Patients Have Their Needs Met

Having needs met is a very basic element of care that is sometimes not able to be done if the patient cannot be understood by healthcare providers. Ashworth (1987) identified communication as an important way for patients to have their needs—physical, social, psychological, and spiritual—met. LRT can facilitate this process by enabling full reciprocal communication. Non-vocal ventilated patients have repeatedly asserted that such needs were not met (Frace, 1982; Hafsteindottir, 1996; Jablonski, 1994; Johnson & Sexton, 1990; Schumann, 1999; Urden, 1997). Nurses have admitted that patients with severe communication impairments had needs that were not met because of the patient's inability to speak (Hemsley et al., 2001).

The author has noted that non-vocal patients' needs are not always as predictable as they might seem. For example, one patient was most concerned about being sure her healthcare providers knew what insurance policy she had. Another patient wanted to be sure her pocketbook was in safe hands. For each of these patients, these were the main issues they wanted to convey to the staff and their families.

Maslow's hierarchy suggested that people need to have their most basic physiologic and safety needs met before meeting the needs of love, esteem, and self-actualization (Maslow, 1970). When a non-vocal individual cannot be understood, however, even the most basic needs may go unmet. If the ventilated individual finds that it takes great effort to make him/ herself understood, that energy may be expended on the lower more basic elements of Maslow's hierarchy. The higher needs may never be met during this time of illness, when they may be very important. As Newman (1997) suggested, people can expand to a higher level of consciousness even when faced with a difficult circumstance. This higher state of being may be difficult to achieve if only basic needs were being met. LRT may enable non-vocal patients to have both basic and higher needs met.

Hupcey and Zimmerman (2000) found that critically ill patients, half of whom were intubated, had a strong need to

know what was occurring around them, and they had a particular need for reorientation and reassurance. Todres, Fulbrook, and Albarran (2000) gave an example where a ventilated participant wished for someone to hold her hand but no one could understand her. The authors stated, "when someone is in distress and cannot communicate their needs, we tend to look for the more technical reasons for the distress...rather than the more subtle human needs such as intimacy or reassurance" (p. 283). This unmet desire may have been identified if a LRT was available and utilized.

Qualities of a LRT

A lip-reader translator obviously needs to be someone who is proficient in lip-reading. Some people are naturally better at deciphering mouthed words than others. People with hearing loss generally are expert lip-readers. Healthcare professionals with hearing loss would be the ideal candidates because they possess the skills required to lip-read translate along with having an understanding of health issues that may be facing the patient. They are likely to be less intimidated by the heavily technologically oriented environment that typically surrounds ventilated patients. Lip-readers interested in becoming LRTs may be required to learn the basic tenets of translating prior to providing this service. Lip-reading translators can work as independent consultants and offer their services to various facilities' interpreter services departments, or they may work for one specific facility. The referral is received when a request is made to interpreter services by the family or a healthcare provider. A potential LRT should take care to explain his/ her role clearly to interpreter services, as this service is likely not a familiar one to interpreter services. The author has found that LRT services are often confused with oral and sign language interpreting.

Conclusion

Negative emotions are lessened when patients perceive that they do not have communication problems (Riggio et al., 1982). Clearly, it is essential for health care providers and families to understand what the non-vocal patient is saying so that miscommunication can be reduced and needs can be met. Lip-reading translation, ideally provided by healthcare professionals with hearing loss, is an exciting new means to facilitate non-vocal patients' communication.

In the USA, there is great importance placed on the need for people to be able to communicate. American laws mandate that translators be provided for patients who speak a foreign language, so that patients and healthcare staff can communicate effectively. Interpreters are also mandated for those with hearing loss who require such a service. Such translating services allow patients to maintain their autonomy and have their needs met (Solomon, 1997; Tang, 1999; UMass Memorial Health Care Interpreter Services, 1999). It would be ideal if LRT services were routinely offered to non-vocal patients. Providing LRT services could help fulfill the ethical obligation health care professionals have to allow non-vocal individuals' voices to be "heard" and it will enable patients to receive more holistic care from their healthcare providers. No one should have to be "left screaming, but silently" (Urden, 1997, p. 104).

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