Communication Problems in the Intensive Care Unit

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Hospitalization in an intensive care unit is often physically uncomfortable and socially disorganizing. The ordinary forms of conversational participation that generate and sustain a sense of agency are breached when the patient cannot communicate in socially consensual “real time.” Using my own experience in an intensive care unit, I describe how delayed speech, through the use of an alphabet board, frequently leads to a host of interactional problems and mutual accusations about character. I attempt to show that the fabric of self and the perception of quality of care are achieved through “real time” communication. I also describe the differential communicative structure of those who will not and those who will use my alphabet board. Those using the board exhibit, through board employment and through the “local” topics discussed, a depth of common culture between them and me.

MONITORS AND COMMUNICATION

I was initially interested in writing about Jean Baudrillard’s television screens as a displacing hyperreality of today (Baudrillard 1983, 1990). I proposed to use the idea of screens and the displacement of the person and experience in the context of the monitors in the intensive care unit (ICU). The monitor screens, in my experience as a hospital patient, seemed to constitute multiple shifting loci of the self, consonant with Fredric Jameson’s description of the postmodern self and identity (Jameson 1984). I sometimes thought I had become like William Gibson’s (1984) characterization of a human with cyborg parts. I had to look at the monitor

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screens to find out if I was alive, how close to death I was, and if I were making any progress to recovery. The monitors were my constant focus when I was alone. They were, as well, the focus of those taking care of me. My heart rate was monitored, as well as my blood pressure, respiration, oxygen saturation level of my blood, the other blood gases, my temperature, urinary output, the infusion rate of my medications, and my prostrate body was monitored by a television in the ceiling. I lived in and by the collective scanning of the monitors by me and by my caretakers.

Let me illustrate this point about living in the monitors. When an ICU nurse would come into my room she or he could flick a remote switch on their belt and the monitor readouts of other patients would be projected on my monitor screen. That way she or he could keep track of other patients while working in my room. I was at first unaware that my nurse routinely switched on my neighboring patient’s readout on my monitor. I would look at and listen to my monitor and become alarmed at the falling blood pressure, the irregular cardiac rhythm, the low oxygen saturation level, and the bells and buzzers that would go off to signal the other patient was in need of immediate life saving assistance. Thinking it was my readout, my blood pressure would jump to near 200, my respiration rate would increase to 40 per minute, my oxygen saturation level would sink to 80s, and my own monitor alarm bells and buzzers would go off.

It was this confusion of living in monitor screens, whether your own or mistakenly other’s, that caught my analytic attention. I proposed to write about the displacement of the self by the screens, with the added dimension that the monitor screens were not only located in my room but also at the nursing station, about 100 feet away. The displacement was not only characterological, in terms of finding the truth about who you are in the screens, but spatial, as well. Most of the monitor reading, so at least you thought and hoped, took place at the nursing station. The placement of careful and continuous reading of the monitors at the nursing station may have been a panoptic dream, but it effectively removed critical reading of factors concerning life and death, as well as televised bodily behavior, to a remote, unseen location. Additionally, the actions derived from this information were formulated in an invisible place, a site beyond personal influence.

However, when I started writing the paper on the monitor screens, I piled page after page on my communication problems with the nursing staff, physicians, and other workers on the hospital floor. I am afflicted with a neuromuscular disease and I cannot talk or communicate in anything approaching the social consensus of “real time.” I came to feel as if I had deserted my initial project of describing my uncomfortable journey in the cyberspace of the monitors. I faced a dilemma of putting aside the description of my communication problems and proceeding with the theme of the