THE PROCESS OF DECISION MAKING FOR COMPETENCY DETERMINATION OF THE CRITICALLY ILL INDIVIDUAL FOR CONSENT TO TREATMENT

by

JOAN LOUISE PROCIUK

B.S.N., The University of Saskatchewan, 1980
B.A., The University of Saskatchewan, 1980

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Department of Nursing

The University of British Columbia
Vancouver, Canada

Date October 14, 1994
ABSTRACT

The purpose of this study was to investigate the process of decision making that nurses use when determining whether critically ill individuals are competent to consent to treatment. Grounded theory was employed as the research approach to this qualitative study. Through the use of theoretical sampling, data was collected from thirteen informants through audiotaped interviews. The findings of the study reveal that nurses use a subconscious process of decision making. Through the normal course of patient care, nurses acquire considerable knowledge and understanding of their patients. As nurses come to know their patients they make decisions about patient competency. The process of decision making consists of four stages. In the first stage, the nurse assimilates knowledge about the patient’s illness and initiates the nurse-patient relationship. During the second stage, the nurse comes to know the patient’s responses to their illness and to the environment. In stage three, the nurse learns about the personal aspects of the patient. Finally, in the fourth stage, the nurse integrates the knowledge gained from the first three stages of the process, and tests the patient’s decision making abilities. The completion of all four stages of the process places the nurse in a position to make a clinical judgment about the patient’s competency. However, for these informants, a determination of patient competence does
not always ensure the patient's involvement in decision making.
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CHAPTER I: INTRODUCTION

Background to the Problem

Individuals are generally admitted to intensive care units because they are either critically ill and require life support for organ-system failure, or because they are in stable condition but need close monitoring to prevent sudden complications or rapid deterioration (Groh, 1987). Despite the severity of illness or the need for critical care services, critically ill individuals retain basic human needs which include having their choices respected (Fry, 1987).

The principle of autonomy implies that individuals have the right to determine courses of action that affect their existence and fundamental well-being according to their values and life plans (Jonsen, Siegler, & Winslade, 1992). Respecting an individual's autonomy denotes recognizing the individual's capacities to hold views, make choices, and take actions based on personal values and beliefs (Beauchamp & Childress, 1989). Furthermore, respecting autonomy implies treating the individual in such a manner so as to allow or enable the individual to act autonomously. The principle of respect for autonomy is a moral requirement of nursing practice (Fry, 1987). In its Code of Ethics for Nursing, the Canadian nursing
profession has taken a strong stand on the duty of respect for individual choice (Canadian Nurses Association, 1991). Therefore, in intensive care environments, it is important that the nurse cares for the critically ill individual in such a manner that it will be seen by the individual at that time, or in the future, to be in his or her own best interests (Cassell, 1986).

Informed consent is the legal mechanism by which the autonomous choice of an individual is protected (Youngner, 1986). Informed consent to health care means an "autonomous authorization" of an intervention, or of involvement in research, by an individual (Beauchamp & Childress, 1989). It is important to note that, in the hospital setting, informed consent is an ongoing process that occurs between the individual and each member of the health care team who provides care for the individual. Informed consent begins with the hospital admission procedure, and continues until the individual is discharged from the facility. Informed consent may be expressed orally or in writing, or it may be inferred from a patient’s conduct (Wilkinson, 1993).

Competence is a precondition of being able to authorize autonomously (Beauchamp & Childress, 1989). However, there is little agreement on how competence should be defined and how competence should be determined (Elliot, 1991; Silberfeld & Checkland, 1993). Traditionally, physicians have
held responsibility for determining individual competence for consent to treatment (Miller, 1989). It is the physician who has been asked for his or her opinion about an individual’s competence (Janofsky, McCarthy, & Folstein, 1992). Nevertheless, most competency "determinations have been based on inadequate information and few examinations specify the functional nature of the incapacity" (Silberfeld, 1991a, p. 166). Furthermore, competence is not usually questioned if an individual is alert, gives no evidence of confusion, and agrees to what is being proposed. Nonetheless, while such an individual may appear to be agreeing, he or she may not actually be competent to provide informed consent. For these and other reasons, determination of competence to consent is a concern.

Recently, the need to improve the process of assessing individual competence has been identified; more specifically, there is a need to clarify what exactly constitutes competence, the clinical criteria for context specific evaluations of competence, and the identification of who should be competency assessors (Elliot, 1991; Silberfeld, 1991a). Current clinical practices recognize the nurse as a partner in the informed consent process (Varricchio, Hooper, Maurer, & Santas, 1993). Illness, technology, and medications often compromise an individual’s ability to assert his or her autonomy. Often it is the nurse, who is with the individual for long periods
of time, who is the one called on to make judgements about the individual’s competence.

The concept of the nurse as patient advocate has received considerable attention in the literature (Fowler, 1989). Advocacy is a morally based concept that may be viewed as a philosophical basis for nursing. The patient advocacy role for nursing implies the guardianship of patient rights, the preservation of patient values, and the conservation of patients’ best interests (Varricchio et al., 1993). In respecting the wishes of the individual, the patient advocacy role directs the nurse to assist the individual to express his or her wishes clearly and carefully (Fiesta, 1988) and to enable the fullest expression of individual autonomy possible. To enact such a role, the nurse must assess the individual’s ability to comprehend and to act on information and the individual’s physiological and emotional state and its impact on decision making (Fiesta). In essence, the nurse makes a determination of competency, and acts as a patient advocate based on that determination. However, the decision making process that nurses use for determining individual competence is unclear.

Competence determination has recently been addressed in the medical, psychiatric and geriatric literature. As well, several research studies have been conducted on the utility of decisional aids for competency
determination (Folstein, Folstein, & McHugh, 1975; Janofsky et al., 1992; Naglie et al., 1993; Rutman & Silberfeld, 1992). There is some literature on informed consent that presents a variety of suggestions regarding how nurses might assess the individual's ability to comprehend what is spoken and to understand what is written (Varricchio et al., 1993). There is further research on the nurse's role with respect to individual autonomy and decision making (Davis, 1989; Dolan, 1984). However, there is no published nursing research in relation to the process by which nurses make decisions about individual competence for consent to treatment. The lack of data about competency assessments as they are practiced is a gap in nursing knowledge.

**Problem Statement**

Being critically ill often threatens an individual's ability to exercise autonomy in decision making with respect to his or her life and health (LeVeille Gaul, 1990). Fortunately in these situations, nursing's advocacy responsibilities and the ethical duty of respect for individual choice, which are clearly articulated by the nursing profession, direct the nurse to assist and to respect the individual in asserting his or her autonomous choice. For example, in respecting the autonomous choice of a critically ill individual, the nurse as patient advocate often speaks on behalf of the individual. Nevertheless, prior to respecting the individual's choice, assisting the
individual in expressing his or her choice, or advocating on behalf of the individual, the nurse must first decide whether the individual has the resolve for autonomous choice. In essence, the nurse must make a decision about whether the individual is competent. However, the decision making process that nurses use in determining individual competence remains unclear. Given the significance of a determination of competency, it is important to gain an understanding of the process by which nurses make decisions about individual competence for consent to treatment.

**Purpose of the Study**

Nurses play an important role in determining the competence their patients' have for autonomous decision making. The intent of such a role is to help ensure that competent individuals participate in treatment decisions about their health and life, and that incompetent individuals are protected from the harmful effects of their decisions (Drane, 1984; Elliot, 1991). The purpose of this study is to increase nursing knowledge regarding the process of decision making that nurses use for determining individual competence for consent to treatment. Examination of the broader context of decision making may provide the basis for higher level inquiry into the specific criteria that nurses use for individual competency determination.
Research Question

This study will seek to answer the following question: What is the decision making process that nurses use for competency determination of the critically ill individual for consent to treatment?

Definition of Terms

1. Critically ill individual: Any adult who is admitted to an intensive care unit (ICU) because he or she is either critically ill and requires life support for organ-system failure, or because he or she is in stable condition but needs close monitoring to prevent sudden complications or rapid deterioration. The individual also participates in decision making regarding his or her life and health.

2. Intensive Care Unit: A specialized unit in a hospital that offers an environment of technology and specialization in which an individual’s vital life functions can be monitored, recorded, analyzed, supported, or altered.

3. Intensive Care Nurse: A registered nurse who uses advanced life saving technology, assessment, and management skills to prevent death and actively restore health to the critically ill individual.

Assumptions

Two assumptions are pertinent to this study. It is assumed that there are critically ill individuals admitted to the ICU who participate in
decision making regarding their life and health. In addition, it is assumed that the intensive care nurse uses a decision making process to determine the critically ill individual's competence to provide consent for treatment.

**Significance of the Study**

Examination of the process by which nurses make decisions about individuals' competence for providing consent to treatment is justified for a number of reasons. First, the ethical principle of respect for autonomy is highly valued in the Western world. As a result, competent individuals are encouraged and supported to participate in decisions regarding their life and health. Since nurses are often with their patients for longer periods of time than other health care professionals, it is often nurses who are called on to make judgments about patients' competence. Nursing's ethical duties and advocacy responsibilities often direct nurses to make decisions about individuals' competence. Second, with new British Columbia legislative initiatives, such as the enactment of Bill 51, entitled the "Health Care (Consent) and Care Facility (Admission) Act" (Wilkinson, 1993), the responsibility for individual competency determination by health care professionals is clear. However, identification of the expertise required for completing such an assessment is noticeably absent. Third, with the recent focus of nursing on the informed consent process, and the identified gap in
nursing knowledge, it seems timely to conduct this study. Study findings may assist nurses by identifying strategies that may help determine when and why an individual is incapable of making his or her own decision (Elliot, 1991).
CHAPTER II: REVIEW OF THE LITERATURE

Introduction

This review of the literature, pertinent to the problem of competency determination, begins with an examination of informed consent in health care, and is followed by a review of the concept of individual competency. The literature review addresses the status of competency assessments, and reviews studies on decision making and competency assessment. Lastly, the limitations of competency assessment are discussed.

Informed Consent in Health Care

Mr. Justice Cardozo, in 1914, in Schloendorf v. New York Hospital, stated that "every human being of adult years and sound mind has a right to determine what shall be done with his or her own body" (Searight, 1992, p. 752). This principle is the foundation of the legal doctrine of informed consent.

Informed consent is the legal mechanism by which the autonomous choices of an individual are protected (Youngner, 1986). Autonomous choices are actions, such as consents and refusals of treatment (Beauchamp & Childress, 1989). For an act to be autonomous, it must be intentional, with understanding, and without controlling influences.
Informed consent authorizes a professional either to initiate a treatment intervention, or to involve an individual as a subject in research (Beauchamp & Childress, 1989). Traditionally, according to bioethical literature, it is the physician who has had the primary ethical obligation to obtain informed consent from the patient (Davis, 1989). However, that literature has failed to reflect the fact that the informed consent issue is not solely about medical interventions and medical research participation. The nurse also has a duty to obtain informed consent for nursing interventions and nursing research participation.

Recently, attention has focused on the advocacy role of the nurse in the informed consent process. For example, the concept of the nurse as a patient advocate includes ensuring that the patient comprehends the treatment proposed and the potential consequences of agreeing to or refusing the treatment (Varricchio et al., 1993). In California, failure to act as a patient advocate as circumstances permit places the nurse susceptible to loss of licensure on the basis of incompetent practice, even if the patient is not harmed (Fowler, 1989). Furthermore, the nurse advocacy role includes enhancing the competence of patients and families by educating them about the patient’s illness and treatment, and the questions they need to ask (Marchette et al., 1993). The nurse should also determine the best approach
to use to obtain informed consent by considering the environment, time frame and inclusion of others (Varricchio et al., 1993). If the nurse judges that the individual’s ability to understand information and/or to make decisions is impaired, then it is the nurse’s responsibility to initiate, delay, and/or surrogate decision making.

The nurse advocacy role is reflected within the context of the nurse-patient relationship (Fowler, 1989). In this relationship, the nurse, through decisional counseling, assists the patient in recognizing and clarifying his or her values and in making health care decisions that reaffirm and uphold those values (Fowler, 1989). Nevertheless, this model of advocacy requires that the patient be self-determining and able to participate in the exploration of his or her values and in the decision-making process. Fowler states that patients no longer capable of such interaction require an alternative form of advocacy.

**Individual Competence**

Competence is a precondition to being able to authorize autonomously (Beauchamp & Childress, 1989; Roth, Meisel, & Lidz, 1977). However, there is little agreement on what defines competence (Elliot, 1991). Miller (1989) states that competence is the ability to understand, to weigh alternatives, and to make judgments that promote personal values, goals or interests. Rutman
and Silberfeld (1992) view competence as the degree of "fit" between an individual's capacities, resources and support and the demands of that individual's environment. Janofsky et al. (1992) describe competence as the ability to understand the proposed treatment including the risks, benefits, and alternatives, as well as the ability to understand the right to informed consent.

Elliot (1991) describes a competent individual as an adult who thinks and acts in roughly the same way we do, including language, conduct, and paradigm. A competent individual understands the nature and consequences of his or her actions or choices. A competent individual has intention, beliefs, and reasons for his or her choices, and acts knowingly and willingly. Elliot states that the mental life and behavior of a competent individual would be enough like our own that we would be able to determine whether that individual would be accountable for his or her choices.

An individual may be both competent and mentally deficient (Elliot, 1991). Some mental deficiencies may not be relevant in considering whether an individual can be held accountable when making health care choices. For example, an individual may be unable to count, but able to make choices regarding his or her health or life. Therefore, competence encompasses more than cognitive abilities.

The legal standards of competence for an individual include being able
to communicate a choice, to understand relevant information, to appreciate the current situation and its consequences, and to manipulate information rationally (Appelbaum & Grisso, 1988). Furthermore, the individual must be able to understand his or her role in the decision making process. The law presumes that an individual is competent unless shown to be incompetent (Appelbaum & Grisso, 1988; Silberfeld, 1991a).

Competence may be viewed as being of two types, global and restricted (Silberfeld, 1991a; Silberfeld, 1991b). Global competence refers to the capacity for all tasks. Restricted competence refers to the loss of one or more specific abilities. An example of restricted competence is that an individual may be incompetent to carry out the activities of daily living, but competent to make health care decisions. Competence is not a fixed state, but may fluctuate in response to illness, treatment, metabolic factors, or the effect of medications (Younger, 1986).

A competent individual can make a poor choice that he or she may regret later (Elliot, 1991). However, poor choices are part of ordinary life. What is most important is that the decision belongs to a competent individual, and that a competent individual’s decision must always be respected. On the other hand, an incompetent individual must be protected from his or her decision because the decision does not belong to that
individual in the same sense.

In the presence of a variety of theoretical conceptualizations of individual competence, many enquiries, commissions, task forces, and competency experts have attempted to develop guidelines and instruments that can be used in the assessment of competency. The next section of the literature review outlines the work that has transpired on competency assessment to date.

**Competency Assessments**

There are increasing demands for competency assessments. However, there is no single test or well-defined, widely accepted standard for the assessment of competence (Beauchamp & Childress, 1989; Searight, 1992; Silberfeld, 1991a; Youngner, 1986). Roth et al. (1977) equates the search for a single test of competency to the search for the Holy Grail.

Numerous enquiries, commissions and task forces have set out to study issues surrounding decision making in health care, and to develop guidelines for competency determination. In the United States, in 1982, the President's Commission, in studying ethical problems in medicine, pinpointed three criteria as determinants of competence: the possession of a set of values and goals, the ability to communicate and be understood, and the ability to reason and deliberate about one's choices (Elliot, 1991). However, these criteria
have proven to be vague and open to differing interpretations. For example, what counts as values or goals? What happens if an individual is missing one out of the three criteria? And, what are the relationships between these three elements? Furthermore, the Commission supported a sliding standard for competence in that the more serious the consequence of a decision, the higher was the standard of competence to be applied. However, there is no reason why making a decision involving risk is more difficult a task than making a less significant decision. The Commission, unfortunately, paid less attention to the question of competency assessment than to the creation of mechanisms of decision making on behalf of those believed to be incompetent. As a result, the Commission did not come up with its own standard for competency assessment, and left unsettled the question of how to decide whether a particular individual's decision should be respected, or overridden because of incompetency.

In 1985, the Governor Cuomo Task Force convened in New York to study life and law with respect to do-not-resuscitate (DNR) orders (Miller, 1989). The Task Force defined decision making capacity as the ability to understand and appreciate the nature and consequences of a DNR order, including the benefits and disadvantages of such an order, and to reach an informed decision regarding the order. However, the Task Force did not
provide guidance about the test or assessment tools that should be used to
determine capacity. Instead, it urged health care facilities to recognize the
importance of the determination of capacity and to develop policies that
provide guidance about how such a determination should be made.

In 1990, the Weissrub Enquiry on Mental Competency in Ontario
concluded that competence must be understood and evaluated in terms of
decision making ability with respect to specific situations (Silberfeld, 1991a).
In other words, competence is task specific and emphasizes ability to make
decisions. The Enquiry stated that decision making should reflect intention
and choice, and that preferences for each outcome need to be specified and
understood in light of values held. Again, criteria for competency evaluation
were not articulated.

It has been put forth that a true competency assessment requires a
long term relationship and familiarity with individual thought processes and
values (Fowler, 1989; Varricchio et al., 1993). Fowler (1989) argues that an
individual's decisions are consonant with his or her values, and therefore, any
competency assessment of an individual should include discovering the
individual's values. However, in the clinical setting, competency assessment
often occurs in a climate of urgency, frustration and anxiety (Searight, 1992).
In these situations, a clinical test or decisional aid for competency assessment
may be of more assistance. Elliot (1991) states that competency
determination should be guided in part by an examination of an individual's
mental function.

The "Mini-Mental State" (MMS) is a global test of the cognitive
aspects of mental functioning (Folstein et al., 1975), and has been used to
assess competency. This test evaluates the cognitive dimensions that underlie
an individual's competency. For example, impaired attention and
concentration may affect an individual's capacity to make choices. The exam,
which consists of eleven questions, provides a simplified, scored form of
cognitive mental status. It takes five to ten minutes to administer and is ideal
for initial and serial measurements of mental functioning. Results can
demonstrate worsening or improvement of mental functioning over time and
with treatment.

The Competency Index may be another useful tool for competency
assessment. The Competency Index is a decisional aid for competency
determination developed at the Competency Clinic at the Baycrest Centre for
Geriatric Care in Toronto, Ontario (Silberfeld, 1991a). The Competency
Index reflects the locus of competency as a social construct not restricted to
any one discipline. The Competency Index outlines thirteen attributes, each
with several levels of severity, related to competency. The attributes include
mental status, cognitive functioning, social functioning and factors related to choice. The Competency Clinic uses the Competency Index alongside a modal examination for competency determination. The modal examination focuses on the area of competency in question, including the specific decision giving rise to the assessment, the legal standards as they apply, and several decision making variables. The decision-making variables include elicitation of preferences, values that underlie those preferences, the trade-offs for alternative choices, and an evaluation of the risk-taking propensity of the individual.

The Hopkins Competency Assessment Test (HCAT) is a newly developed instrument for quantitative assessment of clinical competency (Janofsky et al., 1992). The HCAT is designed to aid the clinician in forming an opinion about clinical competency. The test evaluates the competence of an individual to give informed consent or to write advanced directives. The test takes approximately ten minutes to administer and consists of a short essay and questions for determining an individual's understanding of the essay.

Decisional analysis may be yet another useful approach for clinical competency determination. Appelbaum and Grisso (1988) consider four dimensions in evaluating the quality of an individual's decision. These include
communicating choices, understanding relevant information, appreciating the situation and its consequences, and manipulating information rationally. They stress that one cannot assess an individual's decision making ability if that individual is uninformed.

Drane's (1984) competence model describes an alternative approach to competency assessment. The model relates individual reasoning abilities to three decisional contexts. The individual is held to higher standards of competency as the medical risk increases.

Roth et al. (1977) describe five categories of tests of competency. They include: (1) "evidencing a choice", which focuses on the presence or absence of a decision, (2) "reasonable outcome of choice", which evaluates an individual's capacity to reach a reasonable, right or responsible decision, roughly congruent with the decision that a "reasonable" individual in like circumstances would make, (3) "choice based on rational reasons", which focuses on the quality of an individual's thinking, (4) "the ability to understand", with respect to the risks, benefits, and alternatives to treatment, and lastly, (5) "actual understanding", or giving knowledgeable consent.

**Research Studies**

To date, empirical research on competency assessment and decision making with respect to informed consent is sparse. No nursing research
focusing on nurses' decisions about individual competence for consent to treatment could be found. One qualitative and one quantitative study were identified that examined nurses' responses to patient autonomy in decision making (Davis, 1989; Dolan, 1984). However, neither of these studies described how the nurses determined that some of the patients were autonomous and therefore competent in the first place. Two quantitative studies were also identified that investigated the reasons for, and responses to competency consultations by physicians (Farnsworth, 1990; Mebane & Rauch, 1990). In addition, several quantitative studies have been conducted on the utility of decisional aids for physicians to determine competency (Folstein et al., 1975; Janofsky et al., 1992; Naglie et al., 1993; Rutman & Silberfeld, 1992). In the following section of this chapter, several aspects of these studies are discussed to provide an overview of the research that has transpired on patient competency determination and decision making for informed consent.

Davis (1989) studied nurses' ethical decision making in situations of informed consent. This descriptive study, based on interviews with 27 nurses in two clinical settings, showed that the promotion of patient autonomy is directly affected by hospital structural arrangements. Davis found that, in hospital units, a "culture of values" curtailed by structural arrangements (the
type and location of the institution, staff turnover, the institutional hierarchy, the organization of work, policies, procedures, and the accountability structure) placed boundaries around the roles and functions of patients and nurses in the provision of informed consent. For example, units with high staff turnover were not conducive to a climate where relationships were established with patients. Lack of relationships weakened the knowledge base of the nurse about the patient as a person, thereby detracting from the informed consent process.

Dolan (1984) reported the results of a survey in which 84% of 3504 nurses favored withholding life sustaining treatment for dying patients who indicated that was what they wished. Dolan concluded that nurses made decisions based on patients' wishes and best interests and that they acted as patient advocates.

Farnsworth (1990) reported the results of a study that examined compliance with recommendations from a psychiatric consultation service following 90 requests for competency evaluation. He found that competency evaluations were sought primarily for individuals who refused to follow medical advice. Mebane and Rauch (1990) studied the characteristics of 50 consecutive requests for competency evaluations. They also found that competency assessments were frequently requested for patients who refused
to participate in diagnostic or treatment plans, and for patients who threatened to leave against medical advice.

Folstein et al. (1975) reported on the reliability and validity of the MMS exam. The MMS exam attempts to make more objective what is commonly a vague and subjective impression of cognitive disability. Two groups of psychiatric patients were given the MMS exam. Group "A" consisted of 69 patients with clear clinical conditions of dementia, depression with cognitive impairment, and depression and 63 "normal" subjects from a senior citizens center. Group "B" consisted of 137 consecutive admissions to hospital. Examination of Group "B" was done to improve the impression of validity by standardizing the MMS in a consecutive series of admission. Results from Group "A" showed that the MMS exam separated the three diagnostic groups and the "normal" group from each other. Also, scores dispersed in a fashion agreeing with the severity of the difficulty. Results from Group "B" showed that the MMS mean scores were similar for all the diagnostic groups. The results also showed that the MMS exam is stable, whether administered for a second time at 24 hours or 28 days or by single or multiple examiners. It was concluded that the MMS is a valid and reliable exam.

Janofsky et al. (1992) reported the results of a study validating the
HCAT. Forty-one medical and psychiatric inpatients answered the questionnaire after reading the essay while hearing it read aloud. The MMS exam was also administered to each patient. A psychiatrist, who was blind to the HCAT and MMS exam scores, later examined the patients for competency. The results showed that the HCAT is a reliable screening tool for rapidly screening patients for competency to make treatment decisions. The results also showed that the MMS exam failed to differentiate competent patients from incompetent patients with reasonable sensitivity or specificity. The researchers concluded that specific tests of competency are needed in addition to standard psychological tests such as the MMS exam. Furthermore, they suggested that screening patients for clinical competency is possible and economically feasible.

Naglie et al. (1993) evaluated the clinical utility of the Competency Index. Sixty-four psychiatry residents were randomized to carry out mental capacity assessments on simulated cases with, or without, the use of the Competency Index. Results showed that the Competency Index did not improve the ability of the residents to make mental capacity assessments, and that the mental capacity determinations of the residents had a high level of agreement with experts’ determinations.

Rutman and Silberfeld (1992) retrospectively examined 35 competency
assessments performed on 24 subjects by a multidisciplinary competency panel, and compared these findings with the subjects' scores on the Cognitive Competency Test (CTT) and the Mini-Mental State examination (MMS). Results showed that differences of opinion can occur in difficult cases between test and clinical evaluations of competence. The panel found more subjects competent than the test scores indicated. The results also demonstrated a dissociation between "knowing" and "doing", or the "cognitive" versus the "functional or instrumental" components of competence. The findings of this study suggest reasons for incorrect responses may be indicative of sound reasoning than of failure to find the correct answer.

In summary, research on competency assessment has been limited. Studies that have focused on nurses' responses to the autonomous wishes of their patients have not distinguished how these nurses determined the autonomy and competency of the patients in the first place. Medical studies have examined current practices of competency determination, in particular the utility of certain decisional aids. However, findings have revealed a wide range of approaches to competency determination with inconsistent results.

**Limitations of Competency Assessment**

Despite the efforts of many to clarify and standardize the assessment of competence for consent to treatment, there remains a number of problems
when implementing such assessments in the clinical setting. As a result, practitioners have continued to face difficulties in knowing how competency should be assessed. First, there are problems associated with the process of obtaining informed consent. For example, many individuals refuse treatment because of communication problems with medical personnel, interpersonal conflict, intrapsychic issues (e.g., a fear of helplessness), and personality styles (Farnsworth, 1990). As stated earlier, Farnsworth found that the most frequent request for competency evaluations occurred when patients refused to follow medical advice.

Second, there are a number of clinical factors that affect the assessment of competency (Appelbaum & Roth, 1981). The clinical factors may include: varied information provided by the individual, varied information presented to the individual, psychodynamic factors, the stability of the individual's mental status, and the effects of the clinical setting.

Third, a model for competency assessment remains controversial, perpetuating the lack of clarity of what exactly constitutes competence (Elliot, 1991). There are no clear clinical criteria for context specific evaluations of competence (Silberfeld & Checkland, 1993). Terminology such as responsible, rational, or irrational, knowing, knowingly, understandingly, or capable are often used interchangeably without sufficient explanation or clear
behavioral referents (Roth et al., 1977). It remains unclear who assessors of competency should be and how they should be trained (Silberfeld, 1991a). As a result, there is a lack of quality assurance for competency assessments (Silberfeld, 1991a; Silberfeld & Checkland, 1993). Being without a well defined and widely accepted standard for the assessment of competence poses problems in trying to bring uniformity to competency assessment (Silberfeld, 1991a).

Fourth, there is some evidence that more requests for competency assessments result in findings of incompetence than ever before (Silberfeld & Checkland, 1993). One may question whether competency assessments, as they are practiced today, preserve autonomy or further restrict it (Silberfeld, 1991a). Fifth, there is a need for public enquiry to determine the need and frequency with which competency will arise as an issue (Silberfeld & Checkland, 1993).

Summary

A review of the literature has revealed that, to date, there are a number of inconsistencies and limitations regarding our knowledge of the determination of individual competence for consent to treatment. These inconsistencies and limitations open the door to a realm of research themes. Recent attention has focused on the nurse in the informed consent process.
Often, it is the nurse who is with the individual patient for long periods of time and who is the one called on to make judgments about the individual’s competence. Furthermore, because of nursing’s ethical duties and advocacy responsibilities, the nurse often needs to determine individual competency. Given the importance of the determination of competence, a study was undertaken to investigate the decision making process that nurses use for determining individual competence for consent to treatment.
CHAPTER III: METHODS

Research Design

A qualitative approach, namely grounded theory, was employed in this study. Qualitative methods focus on a mode of inquiry "concerned with understanding human beings and the nature of their transactions with themselves and their surroundings" (Benoliel, 1984, p. 3). In the realm of qualitative research, there exist a number of analytical investigative approaches for understanding the world of human interaction. One such approach is grounded theory (Munhall & Oiler, 1986). Grounded theory is a research method used to investigate social processes present in human interaction (Hutchinson, 1986). The aim of grounded theory is the discovery and conceptualization of complex interactional processes. Accordingly, grounded theory was employed as a means to investigate the process by which nurses make decisions about individual competence for consent to treatment.

Grounded theory relies on the assumption that groups of individuals share specific social psychological problems that are not necessarily articulated. Hutchinson (1986) states that when a previously unarticulated problem and its resultant psychological processes are uncovered and
conceptualized, one can explain and predict behavioral variation in a group. Glaser and Strauss (1967), the founders of grounded theory, advocate searching for social psychological problems and processes, viewing them as central to the understanding of behavior.

Grounded theorists approach a problem from the "ground up" (Hutchinson, 1986, p. 113), or from practice to theory. Data collected from interviews, observations and documents are used to generate grounded theory (Stern, 1980). Grounded theory involves both inductive and deductive approaches to theory construction (Hutchinson, 1986; Stern, Allen, & Moxley, 1984). As theoretical constructs emerge and are verified from the data (inductive), new data are collected to test and advance the emerging theory (deductive) (Stern, 1980). The resulting theory may emerge as an entirely new way of understanding the observations from which it was generated (Hutchinson, 1986). A grounded theory approach can therefore provide a method for theorizing about the process by which a group of nurses makes decisions about individual competence for consent to treatment, and a method for explaining and predicting behavioral differences within the group.

**Sample Selection and Criteria**

In qualitative research, the selection of an adequate and appropriate sample is contingent upon the appropriateness and adequacy of the sample
The appropriateness of the sample can be achieved through theoretical sampling. Morse contends that theoretical sampling involves selecting individuals who are articulate, reflective, and willing to share with the interviewer, as well as selecting individuals who are best able to meet the informational needs of the study, as determined by the research question and the stage of the research. The appropriateness of the sample is evaluated by examining if the methods of sampling facilitate understanding of the research problem (Morse, 1991).

The adequacy of the sample refers to the sufficiency and quality of the data. Sample adequacy is evaluated by assessing the relevance, completeness, and amount of information obtained (Morse, 1991). It is also evaluated by determining if saturation is achieved, that is if no new data appear and the resultant theory makes sense.

In qualitative research, rather than using probability techniques to generate a sample, the researcher deliberately selects subjects. In this study, through the use of theoretical sampling, 13 informants were selected by the researcher through consultation with executive members of the Canadian Association of Critical Care Nurses (CACCN), British Columbia Lower Mainland Chapter. All informants received an information letter about the study (Appendix A). Initially, the researcher interviewed critical care nurses
who had broad, general knowledge and experience in competency
determination for consent to treatment of critically ill individuals. These
nurses, referred to as primary informants, were asked to tell their stories
about making competency decisions from beginning to end in order to allow
the researcher to identify common patterns or critical incidents (Morse &
Johnson, 1991). Informants with atypical experiences were also selected so
that a range of experiences and knowledge could be described as richly and
accurately as possible (Morse, 1991). After discovering common patterns and
critical incidents, nurse informants were selected who could confirm or refute
the emerging hypotheses, address specific questions, and expand certain
points (Morse & Johnson, 1991). These informants are referred to as
secondary informants. Through the use of theoretical sampling, the
researcher used gaps in the emerging theory to determine the ongoing
selection of informants. This process continued throughout the data
collection and data analysis phases of the study to help ensure the ultimate
quality of the research. A total of 20 interviews were conducted in this
investigation.

**Data Collection Procedure**

Prior to the first interview, the researcher obtained written consent
(Appendix B) and demographic information from each informant (Table 1).
Table 1. Demographic Information About the Informants

<table>
<thead>
<tr>
<th>Informants</th>
<th>Age</th>
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<th>Years Practicing Nursing</th>
<th>Years of Critical Care Experience</th>
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Key:  F=Female; M=Male
Appropriate settings and times to meet with each informant were then chosen. Data were collected from each informant through audiotaped interview sessions lasting approximately one hour. The researcher determined which informants would be interviewed, when, and how often, and also decided when to terminate nonproductive interviews.

The development of grounded theory relies on the researcher engaging in constant dialogue with the data in order to establish direction for further sampling (Hutchinson, 1986). In the present study, the researcher initially started the interview with an open-ended question such as, "Tell me about your experiences of deciding whether critically ill patients can consent to treatment" (Appendix C). However, as the data collection progressed, the researcher altered the nature of the interview to investigate emerging categories and contrasting relationships between the concepts.

Immediately following each interview, field notes encompassing an objective description of the setting and the informant were written. Verbatim transcription of the audiotapes along with the field notes formed the data base for this study.

**Data Analysis**

Data analysis began immediately, allowing the researcher to change focus when necessary, and to pursue leads revealed by the ongoing data
analysis (Hutchinson, 1986). Rather than following a series of linear steps, the researcher worked within a matrix where several research processes were in operation at once (Stern et al., 1984). For example, the researcher examined and began to code, categorize, and conceptualize the data as they were received, while simultaneously writing her initial thoughts for the research report. Hypotheses were checked with the incoming data and were verified or rejected.

The first step of the data analysis process involved the coding of the data as they were received. The researcher broke the data into segments by applying a system of substantive codes (Hutchinson, 1986; Stern et al., 1984). Substantive codes are words taken directly from the data that highlight important passages (Stern, 1980; Stern et al., 1984). Code words were written on the margins of the interview transcriptions.

In the second step of the data analysis, coded data were compared with other coded data, including new incoming data, and condensed into categories (Hutchinson, 1986; Stern et al., 1984). Categories are simply coded data that appear to cluster together (Stern, 1980). In this process, some data were discarded as they were deemed irrelevant.

In the third step, a tentative conceptual framework was generated through exploring and establishing relationships between the categories
(Stern, 1980). Through a process of "reduction", the researcher limited the number of categories by comparing them with one another and by determining how they linked or clustered together (Stern, 1980). Literature was also woven into the matrix of data, category, and conceptualization to help expand the emerging theory and to relate it to other theories (Stern et al., 1984). Through selective sampling, the developing conceptual framework was tested by collecting data to prove or disprove the framework hypotheses. Once saturation of the codes, categories, and constructs was reached, or when no new data appeared, a core variable emerged (Stern, 1980). The core variable, or the basic psychological process, illuminates the main theme in the data (Hutchinson, 1986). The core variable occurs frequently in the data, links various data together, should be easy to understand, and explains most of the variation in the data (Hutchinson, 1986). Once the core variable emerged, the researcher coded only those data that related to it (Hutchinson, 1986).

In the fourth step, through a process of "theoretical coding", the data were moved from descriptive to theoretical terms (Stern, 1980). The researcher considered the core variable with respect to its conditions, properties, strategies, and consequences (Strauss & Corbin, 1990). Through a method of "memoing", emerging hypotheses, analytical schemes, hunches and
abstractions were recorded on cards (Stern, 1980). Memos are "sparked" by the data, and therefore grounded in the data (Stern, 1980, p. 23). Through comparative analysis, the memos were sorted, in turn, providing the organization for the research report (Stern, 1980).

Lastly, the substantive theory was written, with the core variable or basic psychological process as the central focus (Stern, 1980). Literature was used to facilitate the explanation of the theory, and concepts were supported by drawing examples from the data (Stern, 1980). The final step was to ask select informants if the formulated theory accurately described the process they use when determining individual competence for consent to treatment in the clinical setting.

Validity and Reliability

Issues regarding the validity and reliability of the research method may limit the study results. When unstructured interviews are the major source of data collection and analysis, aspects of validity and reliability are built into the research design, rather than treated as separate issues of measurement (Brink, 1991). For example, reliability is established by determining the appropriateness and adequacy of the sample (Morse, 1991). In this study, the appropriateness of the sample was ensured through theoretical sampling, which involved selecting informants who were articulate, reflective, and willing
to share information with the researcher, as well as through the selection of informants who were best able to meet the informational needs of the study (Morse, 1991). The researcher used gaps in the emerging theory to determine the ongoing selection of informants. Thus, the sample was representative of the phenomenon under study, rather than the population in general. The adequacy of the sample was determined when a point of saturation occurred, or when no new data appeared and a sense of closure was achieved (Morse, 1991).

Theory validation occurred throughout the data collection and analysis process by examining the data and questioning the informants. Continuous comparative analysis of the data provided a check on their validity, as well as assisted with identification of distortions and inaccuracies (Hutchinson, 1986). The researcher continually formulated and tested hypotheses, and discarded those that did not seem accurate. Contradictory data were sought by investigating atypical experiences so that as many aspects of the phenomenon could be described as richly and accurately as possible (Morse, 1991). As well, the emergent theory was validated by select informants. The truth value of the theory was evaluated against the criterion of "credibility". Sandelowski (1986) contends that credibility is achieved when a study's results present "such faithful descriptions or interpretations of a human experience that the
people having that experience would immediately recognize it from those descriptions or interpretations as their own" (p. 30).

**Ethics and Human Rights**

The researcher obtained permission to conduct the study from the University of British Columbia Behavioral Sciences Screening Committee for Research and Other Studies Involving Human Subjects. Prior to the first interview, the researcher obtained written consent from each nurse informant. The written consent (Appendix B) contained the following elements: (1) an explanation of the study, including the purpose of the study, the taping of the interviews, and the number and duration of the interviews; (2) a statement that the participant was free to refuse to answer any question without consequence, and that he or she could withdraw themselves or any specified data from the study at any time; (3) a statement that all identifying information on the transcripts and written materials would be deleted and replaced with codes to keep all data anonymous; (4) a statement that for confidentiality purposes, the "key" to the codes would be kept in a file in a locked drawer to which only the researcher would have access; (5) a statement that at the completion of the study, the "key" to the codes would be destroyed and the audiotapes erased; and lastly (6) a statement that the transcripts and field notes would be retained for future teaching and research
purposes.

Summary

Grounded theory was employed as the research approach to this qualitative study. The chapter began with an overview of how grounded theory provided a means to investigate the process of decision making used by nurses for determining patient competency. The sample selection and criteria, the data collection procedure, and the steps to data analysis were outlined. The validity and reliability of grounded theory as a research method were also discussed. The chapter closed with a synopsis of the elements of the participant consent form.
CHAPTER IV: FINDINGS

The goal of this study was to investigate and describe the process of decision making that nurses use when determining whether critically ill individuals are competent to consent to treatment. While investigating how nurse informants make decisions of patient competency, it became evident that, while each informant's perspective was unique, there was an underlying process that was common. As the informants recounted how they collected, interpreted, integrated, and tested specific data concerning their patients, it became apparent that the employed process consisted of four stages. Informants who had completed all four stages of the process were comfortable at arriving at a decision of patient competency.

In this chapter, the process of decision making used by the informants for determining patient competency is presented. First, the core category is briefly discussed. Then, the four stages of the decision making process for competency determination are presented. Verbatim statements from the informants are used to illustrate the study findings and to help explain and predict behavioral variation among the informants.

The Core Category: Knowing the Patient

A core category is the concept that reflects the central phenomenon in
a study (Strauss & Corbin, 1990) and relates to all other identified categories. In this study, the identified core category *knowing the patient* is central to the process of decision making for competency determination. The process of decision making for competency determination begins as the nurse "receives" the patient, and progresses as the nurse comes to know the patient.

Initially, the informants were uncertain when asked to talk about how they determine their patients' competency. Some informants were uncomfortable using the term "competency." Several informants preferred to discuss "competency" in terms of "capacity" or "ability" for decision making. Many informants claimed that competency determination is not something that they deliberately do. As one informant stated,

I: It's not something that you set out to do. It's part of your ... assessment, your whole person assessment.*

However, when the informants were asked about whether the patients that they had spoken about during the interviews were competent, they were quick to reply "yes" or "no" and to qualify their decisions. Further discussions with the informants revealed that, through the normal course of patient care,

*Abbreviation Key:

I = Informant       [ ] = Translation of terminology
R = Researcher      ( ) = Omissions to preserve confidentiality
they acquire considerable knowledge and understanding of their patients. When discussing their patients throughout the interviews, the informants demonstrated that they use this knowledge to qualify their claims of patient competency. Making a decision about a patient's competence is thus a process necessitating that the nurse have a sound knowledge and understanding of the patient. For this reason, nurses must come to know their patients as they make decisions about patient competency.

*Knowing the patient* is a complex cognitive process that involves three types of knowing: *knowing the patient's illness*, *knowing the patient's responses*, and *knowing the patient as a person*. As one informant stated,

I: You familiarize yourself more ... with factors that would influence you making a judgment. So, you familiarize yourself with their family and with their history and with the patient.

The first type of knowing, *knowing the patient's illness*, involves gaining an understanding of all aspects of the medical diagnoses, the patient care problems, and the goals of care. Of the three types of knowing, *knowing the patient's illness* is the most general, and can be readily accessed through a review of the medical record, handover report from the previous nurse, discussion with the patient and his or her family, and consultation with other health care team members. Informants stated:

I: It’s much easier to know of their case history, ’cause it’s often written down.
I: You get handover and a case history....So you know about their illnesses and then somebody tells you specifically about ... the various systems of the body and ... what is functioning and what isn't. And then, when you've got that, you then go in there and you immediately start talking to the patient.

I: From what the ward nurse had given me for a report and she had ... been with him for a couple of days. And, when you read back in the chart and his doctor, his GP, came ... down. His respirologist said, ... 'cause I asked him about it, I said, "What's this guy like?" And he said, "Oh, well, he's really tired of all this."

**Knowing the patient's illness** involves knowing the acuity, stability, and stage of the illness.

I: One lady ... I mean she's been a chronic lung patient for years and years on home O$_2$ [oxygen] ... and ventilator support. And, she came in in acute renal failure and near death's door a couple of weeks ago....So she came in totally unconscious. We had intubated ... well, I mean she had her trach [tracheostomy], but they didn't ... take her off her home ventilator and ventilate her in ICU and do a bunch of stuff, but I mean her K [potassium] was 7 and her creatinine was 500 and all that kind of stuff.

I: I think it would depend on their stage of illness, obviously ... patients who are ... being ... treated with ... inotropes, or are in a shock situation, no, they probably aren't competent. They ... don't know how sick they are.

Scientific knowledge pertaining to physiology, pathology, and pharmacology aid in the interpretation of the data gathered about the patient's illness.

I: If they've had major blood loss, therefore you would query, was his brain fully ... oxygenated through the entire process?

I: I really did think when this man came in, he had ... 20% of his
ejection function....None of the anterior of his heart was working. I mean, I only just thought, well, he has peripheral vascular disease, hypertension, CVA [cerebral vascular accident], heart bypass, I mean everything was against him. And yet, we have improved his cardiac output and we have brought his SVR [systemic vascular resistance] down. But, he will be a cardiac cripple.

Previous clinical experience with similar cases also assists in the interpretation of the data gathered about the illness.

I: I think in all my experience of high-quads [quadraplegics], and I have a lot of experience with high-quads, he was probably the worst high-quad ... worst off. 'Cause he couldn't swallow. He couldn't take a drink....He couldn't sip on a straw ... due to his swelling and stuff, and ... so he didn't even have the pleasure of food.

As is demonstrated in the above examples, knowing the patient's illness provides the baseline from which to anticipate possible patient outcomes and responses.

The second type of knowing, knowing the patient's responses, involves discerning how the patient reacts both physiologically and psychosocially to the illness and to the environment. Knowing the patient's responses is a more specific type of knowing than knowing the patient's illness, and therefore takes greater skill to accomplish. Skills of physical examination, observation, communication and intuition are used in acquiring this type of knowing. One informant stated,

I: I think what you do is you observe the patient and you talk to them and you see what their responses are. And it's not ... a conscious thing, but your brain collects data it observes....It's just watching
and ... dealing with a patient, ... throughout that shift, or for the first two or three hours when you're ... assessing them and turning them and suctioning them and ... all the things that you're doing as a nurse to the patient....I think you subconsciously collect data by observing their behavior and their responses to your actions.

Knowing the patient's responses includes knowing that responses can be both behavioral and physiological in nature.

I: I just know that with the woman with ALS [amyotrophic lateral sclerosis], when she didn't agree with you, she just got really tachycardic and agitated and got very worked up so you knew that that wasn't ... that we weren't clueing into what she wanted ... or she didn't agree with it.

I: You can just look at their face and know that they're not hearing anything that you've said, and ... you can tell from their facial expressions and their eyes, and if they're following you or they're looking at you or they're, I mean the face is a good way.

Furthermore, knowing the patient's responses includes knowing whether the response is appropriate and consistent over time.

I: If they're awake, and ... if to me they seem ... kind of appropriate in their response, then I'd feel okay. Then I'd feel comfortable ... knowing that they know what I'm talking about or they know what ... they're going for.

One informant referred to a patient she cared for as "acting normal."

R: Acting normal. What does that mean?

I: Sitting up and reading ... a book. Having a table at her beside with some fruit juice on it ... helping herself to these things....Listening to a Walkman. Having ... those kinds of... having a life that she has a little more control of than most of the other patients. She's in charge of a lot more aspects of her life and going about it in a very logical way.
Another informant described a situation wherein a patient's verbal and physiological responses were incongruent with each other.

I: With her she would say she wanted to ... die but then she was ... she'd be very tachycardic and her breathing was way out of whack. And you're like, "Are you scared about this?" And she'd be, "Yeah." I said, "Well are you sure you really want to do it [die]?" She'd say, "No, I'm not sure yet."

Knowing the patient's responses also includes knowing that responses can be influenced by illness and medications.

I: Unless they are impaired by drugs ... DTs [delirium tremens], whatever, head injuries ... psychiatric problems ... that it's not...how can I explain it?...They're able to make that decision. You know ... when you question people's competency, you kind of question their sanity, I find.

Furthermore, knowing the patient's responses involves knowing how fear, anger and depression can influence the type of response elicited by a patient.

I: I think some of his ... anger and his depression came from a real deep fear and rather than face the fear of ... being ... what I call a cardiac ... cripple, and ... having to alter a lifestyle that he loved ... real drastically. Rather than having to face that, he would just rather say "no" and end it.

I: I think depression ... which, unfortunately a lot of patients get. I think ... they get to the point where they can't ever picture themselves getting out and they just sort of see this day after day of stuck there on the ventilator and ... I think that alters their ... motivation, it probably alters their decision-making as well.

I: I think they get affected by being in hospital ... so long ... things like depression and just illness ... or disorientation can affect ... their ability to make competent decisions about things.
Knowing the patient's responses allows the nurse to get a "feel" for the patient and to know when something is wrong.

The third type of knowing, knowing the patient as a person, involves developing an appreciation for the person as a whole, and not just as a "sick person." This is important because as one informant stated,

I: A patient is a person first, and then this person becomes a patient.

Of the three types of knowing, knowing the patient as a person is the most specific and the most challenging to obtain. Knowing the patient as a person includes knowing the patient's personality, and knowing the patient's idiosyncracies such as his or her likes, dislikes, and preferences.

I: I think that's really important to have them as much as one can 'cause then you get to know their personality, and you know what they like, what they don't like.

Furthermore, knowing the patient as a person includes knowing what the patient knows about the illness and how he or she is coping with it, and knowing what the illness means to the patient as a person.

I: You can learn a lot of their education, like their knowledge base, like from where they're sitting, what their illness means to them or like ... why that they're ... there.

Knowing the patient as a person also includes knowing what the patient's values are and knowing how he or she likes to be treated as a human being.

I: This lady ... doesn't like to be uncovered by the sheet. And you've come to that decision, and not because they've said to you, but
probably just 'cause you've turned them over and the sheet wasn't covering their rear and you just saw them trying to pull them round and it was obvious that dignity and being covered up was important to them.

Knowledge about the patient as a person is obtained through the development of rapport by spending time talking with the patient and his or her family and by observing their behavior.

I: If they have cards or pictures or whatever around ... I don't necessarily do this in the course of a head-to-toe [assessment] but over the course of time - "Oh, is this your dog?" or "Who's this?" Or, when relatives come in ... I learn a lot about my patients from their families.

I: They become more real people to me through their families because of that lack of ability to talk. Their families make a big difference.

Furthermore, knowledge about the patient as a person is attained by observing how the patient and his or her family interact.

I: How the family interacts ... with the patient is going to tell you how you have to interact with him ... to get along.

I: I think just by watching him or her ... and just seeing how ... the family treat them and how they treat the family, sort of says a lot about that person's personality and how they ... like to be treated.

I: If you just hear them talking on their own, you get an idea of what their background is and how they feel about things.

Knowing the patient as a person enables the nurse to gain a sense of the person as an individual and to anticipate his or her desires.

I: I find that if we spent more time with these people, you get to
know them real well. It’s almost like ... you can almost read their minds ... you can almost read what they’re thinking and you know when to ask those questions.

Knowing the Patient's ability to anticipate outcomes and responses

Knowing the Patient's responses ability to get a feel for the patient and know when something is wrong

Knowing the Patient as a Person ability to gain a sense of the person as an individual and to anticipate his or her desires

Figure 1. Types of Knowing

Knowing the patient (Figure 1), through knowing the patient’s illness, knowing the patient’s responses, and knowing the patient as a person, is a subconscious process inherent in skilled clinical decision making for competency determination.

I: It’s a subconscious kind of thing that I’m trying to describe and I don’t think I’ve ever put it into words as to what makes me determine that they can decide.

All of the informants referred to knowing the patient in discussions of their clinical decision making for competency determination. One informant stated:
I: Knowing him as well as I did, I ... must say I was probably the only person who knew him in his ... injured state...I signed an affidavit with the lawyers at the hospital saying this is what he told me...I have no doubt in my mind as far as competency goes with that particular patient because he knew...I would never have any doubt in my mind. I cried my eyes out when he died. But I knew it was what he wanted.

It is through knowing the patient that nurses can determine the patient's capacity or competency to make choices, and that nurses can anticipate and understand what those choices may be. As a result, determining patient competency for decision making creates the possibility for advocacy by respecting the patient's wishes, by preserving the patient's dignity, and by protecting the incompetent patient from the effects of his or her decisions. One of the informants stated:

I: I find myself being an advocate to these patients a lot. And these doctors say, "Yeah, he needs this thing." And I go, "I don't think so. Look at him. He's not ... responding to this and this and he's refusing it. And I can't see any reason why we have to do this." And he [the physician] says, "Well ... he won't know." Like I feel sometimes these doctors say, "Well, he needs it." But he [the physician] doesn't really know.

The Process of Decision Making for Competency Determination

Knowing the patient is central to the process of decision making for competency determination of the critically ill patient. The process of decision making for competency determination is comprised of four stages: receiving the patient, analyzing the data, humanizing the patient, and testing the
patient’s abilities (Figure 2). In the first stage, the nurse assimilates knowledge about the patient’s illness and initiates the nurse-patient relationship. During the second stage of the process, the nurse investigates the patient’s responses to the illness and to the environment. In stage three, the nurse examines the personal aspects of the patient. Lastly, in the fourth stage, the nurse integrates the knowledge gained from the first three stages of the process, and tests the patient’s decision making abilities.

The four stages of the decision making process for competency determination progress rapidly and often simultaneously, taking the nurse, on
average, two hours to two twelve-hour shifts to complete. Following completion of the process, the nurse continues to learn about the patient and to monitor the patient for competency. As a result, the nurse may reinitiate the process at any time. This investigation, however, focuses on the initial process of decision making.

In the following sections, the four stages of the decision making process for competency determination are presented. A discussion of the conditions, properties, strategies, and consequences characteristic of each of the four stages of the process is included. The core category, knowing the patient, which persists throughout each stage of the process, is utilized to discuss variations in the data.

Stage I: Receiving the Patient

The process of decision making for competency determination begins when the nurse "receives" the patient from the previously assigned nurse. This stage of the process is deliberate, controlled, and methodical. The nurse focuses on ascertaining relevant information about the patient's illness and the goals of care. The nurse also focuses on laying the groundwork for the development of a professional relationship with the patient. There are three strategies that the nurse completes when receiving the patient, including assimilating information, initiating the relationship, and securing
Assimilating Information

The informants claimed that they begin to assimilate information about the patient’s illness during "handover". As one informant said,

I: Your initial data starts collecting ... or your process starts when you get handover and a case history.

The informants described "handover" as a report about the patient lasting approximately fifteen minutes, which is presented to the nurse by the previously assigned nurse. The report consists of a case history of the patient, specific information about the functional abilities of the various systems of the patient’s body, and an overview of the family’s involvement with, and reaction to, the patient’s illness.

I: You usually start with the patient’s pertinent history and then go down to his ... past medical history, then, if he’s had any operations ... that are associated with his admission, and then start with the systems. Go from neuro to respiratory, cardiac, GI [gastrointestinal], and then GU [genitourinary], and then ... hit the family. I always like to know what’s happening with the family.

I: I would know about the patient in terms of ... his or her illness ... what brought them to hospital.

I: So you know about their illnesses and then somebody tells you specifically about ... the various systems of the body and ... what is functioning and what isn’t.

The informants concurred that "handover" report provides them with a general, global overview of the patient’s illness. As one informant stated,
I: It's a superficial sort of knowing.

During handover report, the informants indicated that they focus on three properties of the patient's illness, including the acuity, stability, and stage of the illness. The acuity of the illness characterizes the persistence of the illness and can range from acute to chronic. Several of the informants stated that knowing the acuity of the illness helps determine how much experience the patient has with the illness, and how much understanding the patient has regarding the illness. As in the following examples, informants stated that a chronically ill patient often has a more realistic view of possible outcomes than an acutely ill patient.

I: The realistic view of their outcome is sometimes dependent on ... how much exposure they've had to being sick. You know, some people are very ... unrealistic in their outcomes, but I mean you can't really blame them 'cause they don't know any better.

I: The person who is a cardiac cripple probably is realizing that ... he is probably going to die, whereas the person with the fractured limbs ... the trauma patient that rolls in from drinking driving, has got ... fractured legs and that kind of thing. He probably just thinks he gets the legs fixed and he's off to the trauma unit and he goes home. Whereas he doesn't think it's life-threatening.

The stability of the illness refers to the current status of the patient in response to the illness, and can range from stable to unstable. Many of the informants believed that knowing the stability of the illness helps determine how vulnerable the patient is to the illness, and how likely it is that the
patient will be able to participate in decision making. Informants agreed that
an unstable patient is less likely to be able to participate in decision making
than a stable patient.

I: I mean if you’ve got a lot of drugs on board you might not be in a
one hundred percent conscious, sane, frame of mind, but then you
would think that if your blood gases were really low and really out
of whack that you wouldn’t be totally sane.

The stage of the illness refers to the progressive nature of the illness,
such as whether the illness is reversible or terminal. Informants stated that
knowing the stage of the illness helps determine how likely the patient is to
recover from the illness, how reasonable are the goals of treatment, and how
logical are the patient’s decisions.

I: I felt that it was reasonable, in the short term, to continue with
treatment...If we hadn’t been reaching the goals that were set ... then I probably would question what we were doing.

I: This man was a forty year old who was ... viable ... because the
nerve would regenerate and his breathing would be okay, and he
would ... be restored back to quote, "normal health." He would go
back to ... the workforce. He would be productive ... and he was
just not cooperating because it was that man thing that they’re into ...
always in charge.

I: But I mean, this guy was sort of right from the start, "No, no, it’s
over, my life’s over. I want it to end ... it’s hopeless." And ... to
me, he hadn’t given us enough time or given himself enough time,
to see just how extensive the damage was before he decided. "I
don’t want to know, I just want to end it." And that’s what I
thought was inappropriate.

Informants implied that they use scientific knowledge pertaining to
physiology, pathology, and pharmacology to aid in the interpretation of
information received about the illness. Many of the informants used the
two examples of low hemoglobin and diminished oxygen delivery to the brain as
significant when considering patient capacity for decision making. As one
informant stated,

I: I had this incident where a patient ... had a low hemoglobin and,
usually we're taught that anybody who has a low hemoglobin is
usually confused or hypoxemic.

Informants also stated that they use previous experience with similar cases to
help interpret the information they have received about the patient's illness.

I: It depends because in ... my experience, shock doesn't settle in for
awhile.

Based on an interpretation of the information received about the illness,
many of the informants stated that they often draw a tentative "set of
expectations" about the patient that "fit" the disease and the circumstances
surrounding the patient's admission to the intensive care unit. These
expectations help form a mental picture of the patient in the informant's
minds. Often the expectations are based on "stereotyping." For example,
several of the informants stated that they often "stereotype" the patient
according to his or her age. One informant stated,

I: The patient's age ... just gives you an idea of what ... kind of ...
shape the body should be in.
Another informant described other examples of stereotyping as follows:

I: It's to get just sort of have an idea, like if they're ... a 40 year old male from the West End who's involved in a skiing accident, well you think, okay, he probably ... you know, lives in a condo downtown ... takes care of himself....But if you have a 40 year old male who's from Newton who is involved in a ... MVA [motor vehicle accident], well, I'd probably assess, you know the man doesn't exercise ... he's probably intoxicated.

The informants cautioned that sometimes the expectations that they set about the patient can be misleading. As one informant stated,

I: A patient that we had recently came in, found down from an IV drug overdose, okay. So that puts him into a certain category. Right? And you would expect certain things if he was an IV drug abuser....And this guy didn't have a lot of those things. He didn't have track marks. He didn't have horrible veins. He was big and well-nourished and everything so he didn't fit the picture of a down-and-out junkie who ... overdosed and was found down hours later. So that's sort of a situation where ... you start thinking, "Well, maybe this guy had something bad happen to him. Maybe he didn't intend to take a drug overdose, maybe somebody did this to him." And that's, in fact, what's being thought right now as he's in the hospital. If he doesn't make it, it will probably be a homicide investigation.

Therefore, the informants emphasized that they may use the "set of expectations" only as a "jumping off point," and that they verify whether there is any truth to them as they get to know the patient.

I: I guess when you're first getting to know a patient, you ... can sort of ... have a set of expectations that would fit the disease or the accident ... or the conditions that they have. And ... that sort of helps you get to know them.

Assimilating information about the patient's illness provides the nurse
with a baseline from which to compare future patient assessments. In addition, knowing the illness assists the nurse in anticipating possible patient outcomes and responses.

Initiating the Relationship

Following the handover report, the informants said that they approach the patient to initiate the development of the nurse-patient relationship. The informants described two strategies that they use in the initiation phase of the relationship. First, the informants introduce themselves to the patient.

I: "Good morning (John), my name is (Carol). I'm going to be your nurse for today."

In most circumstances, informants stated that they address the patient by his or her first name to help develop a sense of closeness and to help promote rapport. As in the following example, one informant explained that use of the first name is important in securing the type of intimate relationship that is needed between the nurse and the patient in the critical care setting.

I: I usually call the patient by their first name ... I think it develops a closeness with them ... a rapport with them. They can call me by my first name. And, I mean, I'm doing some pretty intimate things to their body.

Informants also maintained that the first name holds special importance for the patient. The first name is the name that the patient is most commonly addressed by. For many women, the first name is the one name that has
always been constant for them. One informant stated,

I: I think it’s important that, when people are confused, it’s the one name that has always remained constant is their first name.
Especially for women. I think that’s ... important.

The informants also asserted that use of the first name will often elicit a quicker response in the sedated patient. As one informant stated,

I: I find, too, with intubated patients and sedated patients, sometimes they’ll respond more to their first name than they will to a Mr. or Mrs.

However, not all of the informants address patients by their first names when initiating relationships. One informant stated a preference for using surnames with older patients. Use of the surname for this informant shows immediate respect for the patient, and signifies to the patient regard for his or her role in the relationship.

The second strategy employed in the initiation phase of the nurse-patient relationship is the use of touch. In the following examples informants described how they held patients’ hands, touched patients’ shoulders, or stroked patients’ foreheads.

I: And ... then I do my little thing and part of that is putting hands on them, so I talk to them a little bit about what I’m doing.

I: I’ll hold their hand or touch their shoulder or something like that.

I: One young girl we had was eighteen. Broke her back. From the minute of the accident, couldn’t move her legs. Came into the hospital screaming and screaming and screaming. "I can’t move my
legs." Naturally, I mean I'm sure I'd be the same way. But I think
I spent all shift ... I'm not saying I'm just so wonderful, I'm just
saying, this is what I would like to have happen to me and all the
time the doctors poking and prodding, I just stood by her ... rubbed
her hair and just explained to her ... talked gently into her ear.
And ... just at the end of the shift, she thanked me....When she
came in she was hysterical....When I left, she was calm.

Informants stated that touch adds a personal, caring, human quality to the
relationship. The informants use touch to promote a sense of calm and
security for the patient, and to help establish a sense of trust.

R: Why do you do that?

I: I've never really thought about it. I think it's just a ... maybe a
calming, or ... maybe it's just ... kind of a trust maybe.

Because of the intense nature of the patient's illness, and the need for the
nurse to acquire as much information about the patient as quickly as possible,
the informants emphasized that the establishment of a close, caring
relationship right from the start is critical.

Securing Communication

The informants claimed that securing an effective means of
communication between the nurse and the patient is crucial to receiving the
patient and learning about the illness. Generally, the critically ill individual is
intubated, eliminating the use of voice for communication and complicating
the exchange of information between the nurse and the patient. As one
informant stated,
I: It’s hard with these patients who are intubated ... cause it takes a long time to ... assess them.

In an attempt to secure communication with the patient, all of the informants claimed that they pose a question to the patient, such as, "Are you having discomfort?" or "Are you comfortable?" following which, they observe the patient's response. As in the following example, a central purpose of these questions is to discern if the patient is able to communicate.

I: I would assess it. Assess ... if they can, how they can communicate. If they can point to a board, or nod their head, or write.

Often the patient will nod his or her head in response, or mouth a reply around the endotracheal tube. Informants stated that in this way they secure a means of communication with the patient that provides for the best possible exchange of information, and for the least fatigue for the patient.

In the critical care setting, a number of methods of communication are available for the nurse and the patient to use. The informants listed the following communication methods: writing, eye signals such as blinking, pointing, hand squeezing to indicate yes and no, letter boards, pre-written phrases, lip reading, and nodding. If the patient is unable to communicate verbally, then writing becomes the next most effective means of communication. In the following examples several of the informants emphasized the value of written communication.
I: And she was able to write, you know, and ... that's a big thing with intubated patients....If they can communicate by writing then you can sort of understand a lot more what they're thinking and feeling than if you're just trying to guess with "yes-no" questions. You know, your communication is a lot more limited.

I: If they can write, that ... is a big help cause then you can kind of see where they're at, if they do understand or not. 'Cause some people nod their head "yes" or "no" and it seems appropriate, but ... when you ask a question it's not.

I: I would say that if they can write that's ... to me, that's almost as good as being able to talk to them.

Informants asserted that the use of verbal and written communication is significant in the decision making process for competency determination. They believe that these forms of communication are important in removing uncertainty about the patient's understanding. Nevertheless, sometimes the patient is unable to communicate verbally or in written format. In these cases, the informants stated that they establish an alternative approach to communication with the patient.

I: He ... actually ... seemed to be able to communicate ... by blinking. We actually were able to set up a communication that way. And with the alphabet board ... just ... those kind of signals....He was able to communicate that way and through his family and we were sort of able to ... understand his ... requirements ... quite early on in his recovery period, which, of course, progressed. So that even though he was on a ... ventilator through a trach [tracheostomy] for ... a long period of time after that, those initial, sort of, two stages to his disease process, ... I felt we were able to realize his competency easily at that stage.
Stage II: Analyzing the Data

Stage two of the process of decision making for competency determination progresses concurrently with stage three of the process. In stage two of the process, the nurse examines the patient's physiological and psychosocial responses to the illness and to the environment. Throughout stage two of the process, the nurse is bombarded with incoming data from the patient. The conglomerate of responses elicited by the patient is extensive and overwhelming, at times, for the nurse. The nurse subconsciously collects and collates the data. As data collection progresses, the nurse begins to analyze the data. By analyzing the data, the nurse attaches meaning and purpose to the responses elicited by the patient.

When analyzing the data, the nurse considers the behavioral and physiological properties of the patient's responses. Several of the informants described the behavioral responses that they had observed:

I: There's the patient that just kind of rolls over and closes their eyes for an entire shift and ... just can't be bothered to really look around or look at the person that's looking after them.

I: I mean, some will just tune out and ... not want to talk to you anymore because you're not picking up on what they want. And they'll just close their eyes and ignore you.

I: If they're looking agitated or trying ... always to get out of bed or shuffling around because they look so uncomfortable in bed, or those that are reaching out to punch you. I would say their body language can give a
lot of signs as to ... how they're feeling.

I: If you left them alone, are they ... with their hands up, sort of picking at the flies, invisible flies, or are they lying peacefully, or are they just looking around them scared?...You just sort of observe their [behavior] ...

Behavioral responses usually indicate how the patient is feeling psychosocially.

Physiological responses are involuntary and purposeful. Informants commonly described examples of physiological responses as heart rate, blood pressure, and respiratory rate. Informants stated that changes in vital signs often indicate that something is wrong. As one informant recounted,

I: I just know that with the woman with ALS [amyotrophic lateral sclerosis], when she didn’t agree with you, she just got really tachycardic and agitated and got very worked up so you knew ... that we weren’t clueing into what she wanted ... or she didn’t agree with it.

When analyzing the data, the informants stated that they analyze the effects of the illness, age, and medication on the patient’s responses. Informants identified six factors commonly associated with critical illness that may influence the patient’s responses, including sepsis, poor arterial blood gases, low hemoglobin, decreased level of consciousness, delirium tremens, and psychiatric problems. Informants concurred that age may be a factor that may influence the patient’s responses. As one informant stated,

I: Age is a big one. A lot of people don’t come into the hospital that
often, and all of the sudden, there you are with all these people coming at you and all the activity going around and they get really flustered and they can’t think straight.

R: And you think that has to do with age?

I: I think ... when you’re like forty or so, you’ll ... you can answer questions faster and that kind of thing, whereas if you’re older it’s like, "Oh, I don’t know," ... they get flustered really quick.

In addition, informants discussed how certain medications, such as sedatives and strong analgesics, may influence the patient’s responses. However, informants stated that they believe that medications administered for pain control usually will not impair a patient’s responses.

Analyzing the data helps the nurse to "get a feel" for the patient and know when something is wrong. Two strategies are utilized simultaneously when analyzing the data, including assessing awareness and examining emotional states.

Assessing Awareness

One of the cornerstones of the process of decision making for competency determination is assessing awareness. All of the informants referred to assessing awareness in discussions of their clinical decision making for competency. The informants also acknowledged the challenges in such an assessment in the critically ill population.

Informants described seven conditions of awareness that they examine:
level of consciousness, environmental cognizance, regard for welfare, attention span, cooperation, eye contact, and communication. All of the informants stated that they begin the assessment of awareness by examining the patient's level of consciousness. The other six conditions of awareness are then examined in random order as the data appear.

I: I mean you start with a neuro check right off the start with your assessment, right? Before your bath, before anything else.

Informants stated that an examination of the patient’s level of consciousness consists of a neurological assessment using the Glasgow Coma Scale. The Glasgow Coma Scale is a tool for assessing the level of consciousness (Teasdale & Jennett, 1974). Informants claimed that patients must be fully conscious to participate in decision making regarding their life and health. Assessing the level of consciousness includes observing the patient’s eye opening, motor, and verbal responses. One informant recounted,

I: I couldn’t get her to ... squeeze my hands or open her eyes, or ... those sort of things.

When assessing the patient’s verbal responses, informants said that they examine the patient’s orientation to person, place and time. In examining orientation, the informants stated that they consider whether the patient’s responses are appropriate and logical. Two informants recalled the following
examples of assessments of orientation:

I: She was still conscious and alert and knew who she was, where she was and what was going on.

I: I'll say things like, "Well, you know, is it 1965?"...Or, something like that. Something totally bizarre. Hopefully, so that ... then I'll see that they have some understanding of time and maybe what's happening.

Following an assessment of the patient's level of consciousness, the informants stated that they begin to consider other aspects of awareness. Several informants stated that they assess whether the patient is aware of his or her environment by observing the patient's reaction to the environment. The patient who is cognizant of his or her environment can interpret changes in the surroundings. Informants recounted the following examples:

I: Like when an RT [respiratory therapist] comes in, somebody new comes into the room, and they sort of question, like with their eyes. They turn and look at the person and then look at me and shrug their shoulders or something like that, to me that's being aware of their environment.

I: That they're aware of their surroundings and ... what is actually going on with them, that they're in hospital, and that they have some illness and it's obviously serious enough for them to be in the ICU.

A number of informants implied that they consider the patient's "regard for welfare." For these informants, assessing awareness includes assessing whether the patient can feel concern for his or her safety and well-being, and can initiate protective action. For example, one informant
stated,

I: Like if I've gone into a room and thought that a patient wasn't necessarily awake, or wasn't all there ... and I've started, say, changing their IV pump ... I've had a patient reach out and touch my arm. And when I turn and I see that they're awake and I explain who I am, then they nod and they let go and everything's fine, but to me that ... shows me that those people are aware, like, "What are you doing to me? Who are you and what are you doing?"

All of the informants stated that they consider the patient's attention span when assessing awareness. Some of the informants claimed that they assess the patient's ability to retain information by observing whether the patient can follow instructions. For example, one informant recalled,

I: He would actually test things and try and help himself out. They told him to do exercises in between and he'd be in the bed trying to do them, or whatever. So, I mean, he was just with it enough that he could ... retain what they said to him.

Informants concluded that a short attention span tells them that the patient is incapable of participating in complex decision making. One informant described the following example:

I: Well, his attention span was ... he'd be with you for a few seconds. You couldn't go into a long and involved discussion about ... going back and having your jaw wired because ... he wouldn't have got any of it.

Many of the informants stated that they believe that "cooperation" can be an indicator of awareness. Informants stated that they assess "cooperation" by observing whether the patient is collaborating with the care
he or she is receiving. As in the following examples, informants assessed awareness in the patient who can be left unrestrained with an endotracheal tube in place.

I: I think it takes a lot of self-control ... days and days on end to have that ... tube in your mouth....I think if you're unrestrained and you have an ET tube [endotracheal tube] in ... I think that takes a lot of ... awareness....That would determine to me right away that that person knows what's going on. If they're not fidgeting with it or touching it, that kind of thing.

I: If their hands aren't restrained that means ... they're totally aware of the situation, totally aware of how important ... the endotracheal tube is or the trach [tracheostomy], how important that is, to keep them alive....And they're not pulling or tugging at ... lines or that kind of thing. So to me, that person is totally aware of what's going on, totally orientated.

I: If they cooperate, they're aware of what's going on.

All of the informants stated that the patient's ability to maintain eye contact during an interaction is often an indicator of awareness. As in the following examples, the informants stated that they believe that eye contact indicates that the patient acknowledges that communication is occurring.

I: It's the only way an intubated patient can acknowledge that they hear what I'm saying to them and so I ... like to see the fact that they open their eyes and look at me.

I: I think if somebody's ... able to give me some eye contact I know that ... at least they're listening.

The informants also claimed that they gain a great deal of information about their patients through observing responses of the eyes. One informant said,
I: The eyes are very expressive.

A second informant stated,

I: There’s something in their eyes, there’s ... like you can tell when someone’s there and when someone’s not there....Not always so clear, but like lots of times ... people communicate with their eyes as much as with their nodding or shaking of their head.

All of the informants maintained that when assessing awareness, they consider whether the patient can communicate with clarity and purpose. As one informant stated,

I: Like her conversation was appropriate and ... purposeful and she asked me questions about what I was doing ... instead of just passively lying there and letting me do things to her.

Verbal communication provides the best validation when assessing awareness in the critically ill patient. However, most critically ill patients are intubated, and therefore unable to communicate verbally. Informants emphasized that these patients can be challenging to assess.

I: How they respond ... it’s hard to put into words ... it’s the way that they look at you when they nod, or when they shake their head ... subtle little things. Sometimes with their hands, like all this non-verbal communication does come through even though they can’t talk.

If the patient communicates by writing, then the note should contain coherent ideas that are appropriate, logical, and in the context of the situation.

I: Logical things about ... when are they going to be extubated, how ... is the weaning going, or something like that, or ... about family coming or, you know something like that. Something pertinent to
the here and ... now, not ... God just came to visit me yesterday, or something like that.

One informant described a situation that emphasizes the importance of written communication in the assessment of awareness.

I: I had an interesting experience with a gentleman who was ... about to be extubated, and he was being lightened up....And he ... had no relatives to speak up and people came to visit him who were friends and they wanted him to sign a piece of paper....Something to do with his finances and they said it would benefit him. But I didn’t know these people and they were not his relatives and ... the man obeyed commands times four, and he nodded appropriately to questions, very much to do with his care, and seemed so, for ... all the criteria that you can say to an intubated person, this person is lucid....But I knew he wasn’t lucid. And, he couldn’t write a proper note to me....He would nod very appropriately to questions and he recognized these people and when the people said, "Would you sign this thing?"...He said, "Yes." But I didn’t feel comfortable with that because ... I knew he wasn’t lucid. So we extubated him a little while later and, by golly, he was not lucid. He was not oriented to time and person ... to time and place. He didn’t know quite where he was and he didn’t know when ... it was.

Because the critically ill patient is generally unable to communicate verbally, several of the informants stated that it is often difficult to be certain about the status of the patient’s awareness. As one informant stated,

I: I think they can be ... in that twilight zone, sort of aware of their surroundings, sort of aware of people around them, but when ... you talk to patients after they’ve come out of these situations, they have no recollection. So you have to wonder whether or not ... they were aware at the time anyway.

Many of the informants stated that they frequently use "intuition" to assist with the assessment.
I: It is really difficult to tell in a concrete way, if a person is truly lucid....And yet, sometimes I know that they are. And that knowing is often ... there's an intuitiveness about it.

Several of the informants described intuition as a "second sense" that develops from previous experience, and from repeated exposure to the patient.

I: It's that instinct that you work with.

I: I think it [intuition] gets strong ... the more ... you're exposed to the patient and ... and deal with the patient. I think you get a stronger feel for them.

I: I think the more experience you get, the better the intuition, the better the nurse.

One informant described intuition as a collection of stored experiences that are used subconsciously in situations where the factual information about a patient's responses are inconclusive. Another informant stated:

I: You know, they ... answered all the questions properly, but there's just something that just didn't add up about what they said or the answers that they gave or the way they said it or something.

Several of the informants claimed that they often experience intuition as a "feeling" that something is wrong. As one informant stated,

I: It's sort of knowing something when there's ... no proof.

In the following example, one of the informants stated that intuitive knowledge often motivates her to go back and examine the patient data again.
I: The patient is orientated to da-da-da-da-da. But ... if you have some intuition sometimes you can pick up a sense of "Well, they are orientated," and ... then it's like, "but, what is that?" But ... it was just something that quite didn't add up and it would push you to go back and search for more.

As a result, the informants believed that intuition can enhance the nurse's knowledge of the patient's responses.

**Examining Emotional States**

Critical illness and admission to the intensive care unit hold many uncertainties for patients. Patients often feel a lack of control and they are vulnerable to the whims of caregivers. As a result, they are often emotional in their responses. Informants described three emotional responses that are commonly expressed by critically ill patients: fear, anger, and depression. All of the informants concurred that these emotional responses can affect the patient's ability to make competent decisions.

Fear is an emotion elicited by danger. The informants stated that fear is often the first emotional response expressed by the critically ill patient. Informants claimed that critically ill patients often experience fear of the unknown, fear of what has happened, fear of what the future may hold, and fear of suffering and dying. Informants stated that as they observe the patient's responses, they look for signs of fear.

Several informants claimed that fear can be challenging to detect in
that fear can be quite insidious in nature. For example, a number of the informants stated that fear may be displayed in the form of anger. Many of the informants found that patients' fears may be displayed in the form of a facial expression. For instance, one informant described fear as a "look of fright" on the patient's face.

I: Some patients can look very scared just looking around and having that look of fright on their faces.

Other informants described fear as follows:

I: It's in their eyes. I don't know exactly what it is, it's that wide-pupilled, wide-eyed thing often ... and physically they do a lot of clutching of themselves or hanging onto things, hanging onto the bars or ... sometimes looking around frantically, those kinds of body languages ... when they're intubated...Or even trying to get out of bed or bucking against the ventilator. They're frightened, they're scared of whatever's going on often times.

I: You'd still see it [fear] in his eyes, you'd still see his ... I guess his restlessness.

The informants recalled that patients often become agitated from fear, and may attempt to escape from the frightening situation. As a result, as one informant stated, patients may attempt to remove equipment and tubings attached to themselves, and may venture to get up out of bed.

Fear and worry often go hand in hand. Sometimes an unexpected admission to the intensive care unit may result in fear, shock, and worry. One informant described common worries of the critically ill patient as
follows:

I: "What about work? Am I going to get paid? Am I going to lose my job? Who's going to take care of the kids?"

Many of the informants stated that patients commonly experience fear due to a lack of understanding. As in the following examples, informants claimed that a frightened misinformed patient may refuse interventions.

I: I had one where he needed to have a simple thing, like a Foley catheter and he's scared. Like he doesn't want it, totally doesn't want it. He's scared....And he was scared because he didn't understand what was going on, why he needed to have this. He thought it was going to hurt. And I said, "Well ... why don't you want it?" He says, "No, No, No." It's embarrassing to him. You could see it in his eyes. And I said, "Well, tell me, why don't you want this?" Well he thought we were going to stick a needle into his bladder and put the tube in that way, instead of putting it where it's supposed to go ... the natural way. And after that he says, "Oh, well, okay. Sure, if that's going to be it, that's it."

I: I guess he'd been recently diagnosed and he hadn't had any other infections and so here he had this pneumonia and the chances were pretty good that if he was ventilated and supported we could get him extubated and he'd be fine. And I think maybe he might not have even known that he had AIDS. He was an older fellow. And he was my patient and he was in a lot respiratory distress and he really needed to be ventilated and he didn't want to be ventilated because he was afraid....I think that maybe he came in with an uninformed sort of idea because there's a lot of propaganda out there right now on living wills, and, not propaganda, but ... this whole right to die ... and right to assisted suicide and that sort of thing. And I think it's particularly strong in ... the people with AIDS, they look at these sorts of issues. So this fellow, I don't think, had really thought things through and [was] really prepared. But he knew that total life support was an awful thing and nobody wants to go on it and nobody wants to die that way. And I guess he was afraid that maybe this is what was going to happen to him.
Informants also claimed that a frightened misinformed patient may also consent to interventions that he or she does not really understand.

I: Sometimes you have these patients that don’t understand ... what’s involved in some treatment. And, they’re scared to ask because they see the doctors, "Oh yeah, they know what they’re doing. I guess I should say yes to this." Things like that. And, you always have that feeling so you always have to make sure that they’re ... that they can say no. Cause some patients don’t.

Several informants stated that fear of suffering and dying may also influence the patient’s decision making. For example, often, the patient may agree to aggressive therapy due to a fear of impending death. One informant described a situation wherein a patient chose to be treated "not because he wanted to live, but because he was afraid that he would have such an awful death that he would basically drown in his own secretions." Another informant stated,

I: I have a real problem with ... people who have made a decision not to be intubated, or re-intubated. And then when they become distressed, they change their mind. I’m not sure how I feel about this. And all of a sudden here we are re-intubating somebody who ... very adamantly has told us they don’t want to be re-intubated. But they get scared when it actually happens, and they ... feel their impending death. And they change their mind. And, I mean I wouldn’t want to be the one to stand there and say to them. "No, here I’ll give you some morphine. I’ll make you comfortable and let you go." But ... they were competent when they ... I mean they’re allowed to change their mind, it’s just that in those circumstances ... I mean when you’re clear-headed and you’ve made the decision and then you’re panicky and you change your mind.

As in the following examples, informants stated that fear, shock, and
worry can override a patient's ability for decision making.

I: He was so terrified of what had happened and what possibly could happen in the future that to me he wasn't thinking logically.

I: I would say until they're able to calm down they probably are in no state to make decisions. They would really have to be calmed down and ... told, really, what's going on so they had some comprehension of what's happening. Because in a state of anxiety or being afraid ... I would think their basic thought is just to get out of here. Get ... out of the frightening situation that they're in.

Informants stated that when they sense a patient's fright, they attempt to calm the patient through reassurance and by determining and providing information to alleviate uncertainty. As one informant said,

I: So ... in cases like that, just ... trying to reassure and explain to them ... why we've done things to them and why they shouldn't be trying to pull at certain tubes and what not.

Anger is another emotional response seen in the critically ill patient. The informants indicated that anger, in comparison to fear and depression, is the easiest emotional response to observe. As one informant stated, she often sees a personality change in the angry patient. Procedures that have been accepted by the patient up until a particular time suddenly become offensive to him or her. In addition, as in the following examples, informants claimed that the patient may verbalize his or her anger, throw objects, or attempt to hit the care giver.

I: But then after a while, [the patient says] "I'm so fucking sick of this." And I find that they get angry, very angry....We do tend to
see a lot of the anger. We get yelled at, sworn at, things thrown at us. Patients refusing, won’t be turned.

I: We see a lot of very diligent families that have been visiting all the time receive a lot of abuse. You know, moms that come every day and done manicures and pedicure, painted the gal’s nails, and suddenly this kid doesn’t, what’s a kid? You could be talking about a 35 year old man whose mom’s still around, right?...Doesn’t want anything to do with his mom and he swears at her. And she might bring him a home baked pie and he doesn’t want it...."Take it back."

Informants stated that the patient may also display anger through direct eye contact. One informant said,

I: They would look you straight in the eye and you say, "We need to suction you." He looks at you that way... to me it means, "No, ... you’re not going to do that." That is ... "I’m not going to be put through this." Things like that, you kind of see that... anger. Almost like, you see that expression, but if they were looking at you almost like a glazed look, you can just kind of see that.

Several informants stated that the angry patient usually refuses assistance, suggested activities and interventions.

I: They don’t want to do anything you want them to do or things that you need to do with them. They say, "No, I don’t want to do that ... I don’t want you to do that. I don’t want to take my meds."

The informants emphasized that the angry patient’s responses are often incongruent with what the patient truly wants. As a result, the informants stated that they usually do not "trust" the angry patient’s decisions.

I: I’m not going to trust what they’re saying because they’re just so darn angry right now.
I: When people refuse to turn, then they're obviously not making a competent decision. 'Cause their anger is overriding that. Because they know what they should do.

Several of the informants stated that the patient may also express anger in response to fear. As in the following example, informants claimed that they analyze the patient's anger to determine its root cause.

I: Fear and anger a lot of the times can go hand-in-hand. Like I did talk about that one time about this lady who came in with ... a gangrenous lower leg ... and she didn't want to be in the hospital. She'd passed out and her friends had brought her in and she woke up in the Emergency Department and wanted to leave. And she was very angry ... and very aggressive. And that's how she behaved on the surface, but then you could sort of look beneath that and see that she was absolutely terrified of being in the hospital and it was manifesting itself with anger.

The informants stated that depression is an additional emotional response that may be experienced by the critically ill patient. Informants claimed that depression can influence the patient's decision making ability.

I: Well it [depression] alters their motivation, it probably alters their decision-making as well.

I: It [depression] influences how they respond.

I: Things like depression and just illness and ... or disorientation can affect them ... or ... can affect their ability to make competent decisions about things.

Informants suggested that depression is often associated with feelings of loss of control and hopelessness. Many of the informants described the following three patient scenarios which are commonly linked with the
development of depression. First, the patient whose recovery from illness is plagued by readmissions into the intensive care unit may experience depression. Informants claimed that the pattern of progress and relapse can be discouraging for the patient.

I: They'll get a little bit better and then they'll have a few steps backwards and you know it's just this sort of pattern where they even get out to the wards and then they end up back with a pneumonia and stuff and ... it can be very depressing for them and I can remember one fellow who was, in fact, in the hospital for over a year and came quite close to being discharged and then just had another relapse and died very soon after that. And, it was quite obvious that he was depressed with the whole situation.

Second, the patient with a chronic illness and a lengthy admission into the intensive care unit may suffer depression. As in the following example, informants stated that a lengthy recovery often creates feelings of incredible hopelessness in the patient. The patient may begin to seriously doubt whether he or she will ever get better.

I: [It depends on] What their disease is and the length of time that they're there, if it's an acute thing, like a trauma versus a Guillain-Barre. You know, something more long-term that [you depend on] other people's ... word for it that you're going to get better. You start to seriously doubt yourself whether you're going to get better. Whereas with a trauma you can sort of ... know that underlying ... you're basically healthy and you're going to get better.

Third, the patient who endures an ongoing lack of control may develop depression. Informants stated that the patient who is largely dependent upon the nurse in order to carry out the activities of daily living may experience
feelings of pointlessness and futility. One informant described a patient with a debilitating illness who was so dependent on care givers for assistance, she became depressed. Her depression was manifested with extreme emotion. For example, every time she was asked to participate in an activity she would break down and cry. The informant described the patient as an "emotional wreck."

I: I just remember her crying a lot whenever anything was done ... if ... weaning was suggested....To even participate in it or little things even, like turning and things like that where ... she'd just break down and cry.

Another informant described the following situation.

I: And I think it was this chronic lack of control that probably contributed to his depression when he had a spinal relapse ... and he was at the point where he could move his hands and everything like this and even bag himself. But this had never really occurred to him that it was an option that he could do, because ... whenever we were [trying] to get him off the ventilator he needed an extra ... little ... bit of help, we would bag him. And ... I showed him that he could bag himself and he ... was just really happy with this because it was an incredible amount of independence ... to be able to do that.

Informants stated that when they observe the patient's responses, they watch for signs of depression. However, informants emphasized that depression, in comparison to fear and anger, is the most difficult emotional response to detect. Depression can be so insidious in the critically ill patient that it is often overlooked. For example, signs of depression may be
misinterpreted as effects of the illness or medications.

Several informants claimed that ambivalent responses to questions may be an early indicator of depression. The patient may appear disinterested in partaking in the care she or he is receiving. The patient may refuse assistance.

I: [When] someone is kind of depressed and you ask them, "Would you like to get up?" And they just shrug kind of, it doesn't matter. Or ... "Are you having pain?" And they always say, "No."...Even though that it's ... for whatever reason that ... just from experience, you know that they probably are having pain. They always say, "No." Or ... they don't want to eat.

Informants stated that they often notice a "lack of fight" in the depressed patient. One informant reported that the patient may look expressionless and lack motivation. Another informant claimed that the patient's affect may appear flat. Furthermore, the patient may appear as if not to care or as if going "through the motions."

I: He just sort of just went through it stone-faced. Like he just went through the motions. Whatever we did ... and he didn't care one way or the other ... like I don't know that he didn't care but he didn't make it known that...like just he sort of, "Well, I've told you what I want and you're not listening to me so." And he sort of withdrew into himself.

Several informants stated that the depressed patient may avoid interacting with the nurse and pretend to be asleep. At the extreme, the patient may "give up" and stop participating in decision making altogether.
I: They just close their eyes and don't respond, sometimes you can ... I don't know what it is but you just know that they ... can hear you or that they understand.

Informants stated that direct observation of responses is not always enough to recognize depression in the patient. Several informants stated that they often require a greater understanding of the patient as a person. One informant stated,

I: Depression comes with a much more understanding of ... the person. And I don't think we always have that opportunity. I think that's why it's so difficult to ... see it.

As a result, informants stated that they often consult with the family regarding the patient's responses.

I: I think the family is better at picking up depression than we are. Because they know them better.

**Stage III: Humanizing the Patient**

Stage three of the process of decision making for competency determination progresses concurrently with stage two of the process. In stage three of the process, the nurse attempts to "humanize" the patient by learning about personal aspects of the patient. Humanizing the patient thus assists the nurse in acquiring an appreciation for the patient as a person. Humanizing the patient also enables the nurse to gain a sense of the person as an individual, and to anticipate his or her desires.

"Humanizing" the critically ill patient can be challenging for the nurse.
Nursing care activities such as monitoring and managing the patient's illness, often take priority over focusing on the patient as a person. Technology, a lack of privacy, and time constraints can also interfere with the acquisition of personal knowledge about the patient. To confront these challenges, the nurse employs four strategies: chatting, observing family interactions, developing trust, and discerning values.

**Chatting**

Following the initiation of the relationship in stage one of the process, the informants stated that they begin to chat with the patient. The intent of chatting is to help establish rapport with the patient. By chatting with the patient, the informants claimed that they begin to learn about the personal aspects of the patient.

Informants stated that they chat with patients while completing routine nursing care such as dressing changes and bed baths. Chatting with intubated patients can be challenging and time consuming. The informants stated that they use the method of communication selected in stage one of the process.

Initially, chatting revolves around subjects other than the patient's illness or care. For example, several of the informants stated that they may ask the patient about his or her occupation, home, family, hobbies, or pets. The patient may have cards and pictures taped on the wall that may trigger
the conversation. As in the following example, informants claimed that they take a "cue" from the patient as to the subject he or she feels comfortable talking about.

I: If they can talk to me, I ask them about what they do for a living and what they've done ... all their lives, like where they've lived ... about their family, ... like I sort of take my cue from them....Usually people will run on with something, like one aspect of it. They're either real proud or like to talk about what they do, or they're real proud about their family and ... I sort of go with that.

Informants stated that patients usually select topics that are important to them. One informant emphasized that taking an interest in the patient and chatting about things that are important to the patient lets the patient know that he or she is respected. Another informant emphasized that listening to, and remembering what, the patient is saying, assists in developing rapport with the patient.

I: Listening [is important], I mean I ... so many of us, not just in nursing but outside nursing, you're talking to somebody and they walk away.

One informant stated that the patient who is acknowledged often develops "a better feeling about themselves" and as a result, tries harder.

One of the purposes of chatting with the patient is to obtain an understanding of the person "outside of the unit, or outside of being a patient." For example, as one informant stated, through chatting with the patient, the nurse may learn that the person is outgoing, personable, caring,
and has a sense of humor.

I: Certain hobbies that they have, you might think, oh, they're outgoing, or ... if they have a lot of family and friends, you can kind of [think] ... they're kind of personable people, or they're quite outgoing, not kept to themselves. Let's say, if they have ... a lot of children around, ... maybe they're a really caring and important person to some people....A lot of times, you can see ... cards in the room ... from employers ... or employees. And the things that they write in there, ... sometimes they say ... kind of funny things and you kind of think, "Oh, he must be a good humored person," or that kind of thing....[I] Get to know them like that.

One informant stated,

I: I do always tell jokes so that I, at least I know if they've got a sense of humor. To me that means, I don't know why, but if they've got a sense of humor, I sort of feel like I can have a better rapport with them. Especially if they've got a sense of humor when they're sick.

Another purpose of chatting with the patient is to observe how the patient responds to simple conversation. One informant stated,

I: I find that the way they respond to simple conversations goes a long way in ... both sort of telling you where they're at mentally but also ... how appropriate their conversation is.

The informants stated that, in time, they focus the chatting into a discussion about the patient's illness. One informant stated that she often uses something physical on the patient, such as a rash or a mole, as a "lead-in" to chatting about the patient's illness. By chatting about the illness, informants claimed that they gain insight into the patient's knowledge and understanding of the illness, as well as insight into what the illness means to
the patient as a person. As one informant stated,

I: You can learn a lot of their education, like their knowledge base, like from where they're sitting, what their illness means to them or like ... why that they're ...

In situations where the patient's illness is unstable, several informants stated that they tend to carry most of the conversation, strategically directing questions to the patient that require only a "yes" or "no" response. For these informants, preserving the patient's energy enables them to continue to ascertain information about the person. One informant recounted the following example,

I: This person was in a lot of respiratory distress so I just was trying to talk to him and calm him down, ask him questions that he can just answer "yes" or "no" to so that he doesn't have to ... exert much energy. And, I don't know, by the time we got back to ICU ... I already ... knew a little bit about him just from sort of the talk on the way across, trying to keep him calm. And I knew about his wife and knew he had kids and ... just sort of knew what he'd been through over the past few hours ... how ... he'd been going into increasing respiratory distress.

The informants stated that they often chat with the patient's family to learn more about the patient as a person. Informants claimed that the family can help enrich their understanding of the patient as a person, by describing the patient and the things he or she liked to do before becoming ill.

R: What do you get from their families?

I: A sense of who they are. Oh, Uncle (Jim) is such a lovely person
and he likes to garden. And ... you find out what their hobbies are] ... that kind of thing....Then the person, I ... start to understand them as a person. And ... that helps me know them as a person. Makes a big difference, families.

I: They become more real people to me through their families, because of that lack of ability to talk....Their families make a big difference.

I: Well, it depends on the family, again ... but I like to find out ... if I can, what these people are like before they come into the hospital. What ... their level of functioning is, what their expectations are ... what their lifestyle is.

Informants also claimed that the family can also provide important information about the patient's experience with, and knowledge of, the health care system.

The informants stated that they continue to ascertain information about the person and the illness through chatting. Several of the informants inferred that chatting takes the formality out of the conversation, places the patient and his or her family more at ease, and promotes more open exchange of information. As one informant stated,

I: I think the longer you have with them and the more that you can talk with them, the more you learn about them.

One informant stated that chatting with the patient and his or her family often brings to light a number of intangibles that combine to give an overall view of the patient's competency.
Observing Family Interactions

In addition to chatting, informants stated that they observe family interactions with the patient. Observing family interactions, helps the nurse gain further understanding of the patient as a person. One informant stated,

I: I think just by watching him or her and just seeing how they ... how the family ... treat them and how they treat the family, sort of says a lot about that person's personality and how they like to be treated.

Several of the informants stated that they observe how the patient responds to his or her family. Informants claimed that often patients appear more aware when interacting with their families.

I: It's something familiar to them that they ... at least that's what I put it down to ... something that they recognize and that's familiar and ... the confusion is sometimes less noticeable.

When this occurs, informants stated that they analyze the patient's response by reflecting on "assessing awareness" in stage two of the process.

Informants stated that observing family interactions also assists them in determining how best to interact with the patient. As one informant stated:

I: Sort of watching ... how the family interacts with the ... patient is going to tell you how you have to interact with him to get ... along.

In addition, informants claimed that observing family interactions provides them with knowledge of the family's background. A few of the informants
also confirmed that observing family interactions helps them gain an understanding of how the patient and family feel about the illness. One informant stated:

I: If you just hear them talking on their own, you get an idea of what their background is and how they feel about things.

Informants also maintained that observing family interactions helps them gain an understanding of the family dynamics. As in the following example, several of the informants stated that understanding family dynamics helps them learn about the patient’s role in the family.

I: They had been married for years and years and years. And, it’s just that she would walk in and she would fuss around and she’ll do all these things. And ... he wouldn’t really speak to her or even try and communicate with her and she would just do the things that he needed done. And, if you watched the pair of them ... and then eventually, I think it was a nurse, she said to her, "Do you two ever speak?" And she said, "No, not really, We haven’t for years. I just know what he needs"...."Well, if he has a decision [to make] it would just blow his mind away ’cause he hadn’t made one for so long."

Informants stated that observing family interactions helps them gain an appreciation for some of the logic behind the patient’s decisions.

I: If a woman is afraid of her husband ... and gives into everything he wants, do you know what I mean? Whether she’s sick and dying or ... not ... even necessarily afraid. I mean a lot of women, like this woman, grew up in a time when ... if your husband said you’re going to be on life support, you’re going to be on life support....I’m taking that as an extreme ...
Developing Trust

All of the informants referred to the concept of trust in their discussions of building relationships with the patient. As one informant stated,

I: I think the first thing you have to do with anybody, ... is develop a sense of trust so that they know that they can count on you.

Many of the informants emphasized that developing trust helps to establish rapport with the patient, which in turn leads to a greater understanding of the patient as a person. However, the informants maintained that developing trust with the patient can be challenging, as they must earn the patient’s trust.

Several of the informants claimed that they initiate the development of trust when chatting with the patient. For example, they may share things about themselves with the patient. Informants stated that sharing with the patient shows the patient that they have more interest in the patient than just obtaining answers to clinical questions about the illness. Informants provided the following examples of how, and why, they share with the patient:

I: "Oh, where did you teach? Have you always lived in this city? Oh, I lived in Ontario myself." Like this kind of a thing, like to me that’s building a rapport, a relationship with someone. And that’s also starting to build a trust.

I: I tell them things about me and ... to me if you’re going to talk to them and not tell them about yourself then that ... there’s no trust there. They have to ... sort of have something on you kind of thing to ... before they’re going to start trusting you.
The intensive care setting is an active environment. Periodically, health care personnel may converge around the patient's bed. At these times, one informant stated that she displays courtesy and sensitivity to the patient's needs by turning a two-way conversation with a co-worker into a three-way conversation with the patient. For this informant, including the patient, demonstrates respect for the patient and contributes towards the development of a trusting relationship. Another informant stated,

I: I don't talk over top of them or around or whatever, I talk to them. Or, if their family comes in and you're talking to family you try and include them in the conversation....They know that you're in tune to them as a person ... just not like a number, like a patient, or whatever, and that you actually relate to them.

Informants stated that they promote the development of trust by keeping the patient informed of his or her situation. In the following example, one informant emphasized how keeping the patient informed of the nursing care that he or she is receiving, helps promote a trusting relationship.

I: I think ... that they do begin to maybe trust you. They know ... if you're somebody that was letting them know ... what's happening....So I think maybe the more you tell them, or let them know about what's happening to them, the more ... they know about what's happening to them, the more ... I guess maybe the more they think you're being honest with them and not hiding things from them. Such as ... I don't know ... I mean, even just small things like taking blood samples or what not....That may be kind of frightening ... somebody thinking, "Oh, what are they doing now?"

The informants stated that they also develop trust by being attentive to
their patients. For example, they answer the patient’s questions, they check on the patient frequently, and they respond to the patient’s alarms promptly. Informants maintained that strategies such as these help the patient feel that he or she can trust the nurse to be there if something goes wrong.

I: So I mean, if they can see that you know what you’re doing or you’re giving them answers that satisfy what they want to know, or can at least find out or whatever. Or if they don’t have to wave at you fifty thousand times to get your attention when they want something....They can see that you’re checking up on them. You haven’t wandered off down the hall and ignored them for awhile and things like that.

I: Their alarms going off forever and ever and ever and he hasn’t bothered to come and answer and I think ... if they can see that you’re there fairly quick they feel better. ’Cause they can sort of have a little nap and knowing that nothing’s going to happen and they’ll be ignored.

Informants claimed that trust is also developed when the patient feels confidence in the nurse. Several informants stated that the patient often feels confidence in the nurse who appears competent in what he or she is doing. One informant stated that the nurse who changes his or her mind frequently or easily, may leave the impression of uncertainty with the patient. As a result, the patient may think,

I: "Does she really know what she’s doing?"

One informant said that the patient feels confidence in the nurse who can take control of the situation and make "good" decisions.
Informants stated that the patient may show confidence in the nurse by agreeing to "take a risk." The critically ill patient often feels safe in the intensive care unit because of the number of health care personnel there. Venturing back into the real world can often be a frightening experience. One informant described a patient who agreed to go outside of the intensive care unit with the nurse for a short excursion. By agreeing to this activity, the patient showed confidence and trust in the nurse.

Developing trust with the patient takes time. One informant stated that the nurse needs a certain amount of focused, "unobstructed, uninterrupted time" with the patient. Informants stated:

I: But the relationship between ... the nurse and patient ... I mean there's every different degree of it, depending on how much time you spend with them and how much trust is established and how much talking is done.

I: I think the more time you have with the relationship between you and the patient, and the more the trust and the building of that relationship, the more bonding and connecting you can do and the better you can judge as to how they're thinking and feeling.

Discerning Values

Discerning values is a fourth strategy used by the nurse when "humanizing" the patient. Patients who are admitted to the intensive care unit bring with them a set of values through which they view the world and operate. Discerning the patient's values provides the nurse with considerable
insight into the personal aspects of the patient.

One informant stated that discovering all of the patient's values is impossible, unrealistic, and unnecessary.

I: They might be worried about the children in Ethiopia but there's not a whole lot they can do about it right now. I mean, and ... they're not going to tell you that. They're not going to tell you that that's going to be a concern for them.

Instead, informants emphasized that they focus on values that are central to the patient's needs in the intensive care environment.

As in the following examples, the informants stated that they determine patients' values by chatting with them and by observing their behaviors.

I: This lady ... doesn't like to be uncovered by the sheet. And you've come to that decision, and not because they've said to you, but probably just 'cause you've turned them over and the sheet wasn't covering their rear and you just saw them trying to pull them round and it was obvious that dignity and being covered up was important to them.

I: This woman must be ... really a private person....She doesn't really like to ... she really wants the commode and she felt terrible when she's ... been incontinent or something like that.

I: If you try and take somebody's wedding ring off 'cause their fingers are tight or something, some people will [react in such a way that] ... you get the impression then that their marriage is precious to them.

I: There was one woman like that ... who wanted to know where her teeth were all the time. She wanted her teeth back in. And ... you got the sense then that she was quite a proud lady, and ... that she
... didn’t really ... like to be seen without her teeth.

One informant described a family who requested to "come in and say prayers at half past six." The informant identified the religious aspects of the family’s and patient’s values with this request.

Discerning values helps the nurse see the patient as a whole person, and not just as a "sick" person. It also helps the nurse develop a personal understanding of the patient. As one informant stated,

I: You get to know their personality, and you know what they like, what they don’t like. And then you can organize your care....Just listening, just sort of watching their behaviors.

Discerning values can help "normalize things" for the patient. One informant stated that through chatting with the patient, she learned that the patient valued food and the "social thing" around eating, liked to bathe in the morning, and preferred reading the paper to watching television. As a result, the informant bathed the patient in the morning, arranged for a paper to be delivered and read to the patient, and arranged for the occupational therapist to complete a swallowing test on the patient. Discerning the patient’s values, and likes and dislikes, helped the informant individualize the patient’s care. Another informant stated that understanding the patient’s values helps her determine how the patient likes to be treated as a human being.

Critical illness and admission into the intensive care unit often place
the patient in a position of dependency. The patient who values independence can be frustrated in such a setting. One informant described a patient who's value of independence was demonstrated in her preference for minimal assistance from the nurse. Another informant described an example of a patient who appeared frightened from "lack of control." The patient continuously asked the nurse "about every little detail about what was happening to her." Discerning values assists the nurse in understanding the patient's behaviors, and in appreciating the patient's decisions.

**Stage Four: Testing Abilities**

The nurse enters the fourth stage of the decision making process for competency determination once he or she has acquired sufficient knowledge of the patient's illness, the patient's responses, and the patient as a person. The nurse does continue to learn about the patient. However, after a period of time, there comes a point at which the nurse is in a position to test the patient's abilities for decision making.

Competency, according to the informants, is being "capable of thought and action." More specifically, informants claimed that competent patients are "alert and awake," "have understanding of their illness and what the outcome is going to be," "are able to process ... information" and "ask questions ... if need be," "are able to make a decision ... and feel comfortable
with it," and can communicate that decision by, for example, writing a "clear, concise note." Competent patients can comprehend "the circumstances" or the consequences of "what it is that they are doing or agreeing to." Several of the informants described competent patients' decisions as "reasonable," "rational," and "logical."

By the end of stage three of the process, the nurse knows about the patient's illness including the patient's knowledge and feelings about his or her illness; has established a sound method of communication with the patient; has assessed the patient's awareness; and has considered numerous other factors, such as emotional states and personal values that can influence the patient's decision making. The nurse now focuses on the patient's decision making abilities. In stage four of the process, the nurse integrates the knowledge gained from the first three stages of the process and tests the patient's abilities for competency in decision making. The nurse employs two strategies when testing abilities: confirming understanding and validating responses.

**Confirming Understanding**

Understanding information is a condition of competency. Confirming understanding is "kind of a judgment thing" whereby the nurse appraises the patient's ability to comprehend information necessary for decision making.
Confirming understanding can be challenging. One informant described a situation where two nurses came to different conclusions about a patient’s understanding.

I: We had a psych. [psychiatrically ill] guy come in on overdose who was coming out of it, but then he usually is on Haldol. And he refused to take his Haldol saying he was allergic to it and one of the nurses said, "No, I won’t give it to him because he’s refusing."...And then she went to tie him down ... because he was pulling out all his lines, and he said ... "No, don’t tie me down." So she said she wouldn’t tie him down because he said he didn’t want to be tied down. And I said, "Do you believe ... he knows where he is, and what’s going on?" And I didn’t believe he did so I would have given him his Haldol....But she wouldn’t have done it.

Several strategies are used to confirm that the patient possesses an understanding of the information necessary for decision making, including disseminating information, testing the ability to grasp concepts, and testing the ability to communicate intelligently.

**Disseminating Information**

The informants emphasized that one of the adjuncts to confirming understanding is ensuring that the patient has received the necessary information. As one informant recounted,

I: The wife kept telling the family, "Oh, no, he’s in the hospital. He’s doing okay." But she didn’t say he was in the ICU....Totally ... total denial. And, "Oh, you’re going to get better, you’re going to walk again." No, he’s not. So he got misinformation the whole time. He wasn’t able to make a choice when he could have.

Most of the informants stated that they frequently play a role in
disseminating information to the patient. Prior to disseminating information, informants inferred that they consider their knowledge of the patient. For example, informants claimed that the angry patient is in no position to receive new information. Knowing that the patient is angry or overwhelmed, cued these informants to select an alternative time for the exchange of information. Informants also claimed that prior to disseminating information to the patient, they take into account the patient's background and knowledge level.

When disseminating information to the patient, informants emphasized the importance of clarifying and simplifying the information. In many cases, as one informant stated,

I: "It's a matter of coming down to the level of a lay person".

Informants also stressed that the use of "jargon" when disseminating information to the patient can negatively effect the patient's understanding. As one informant stated,

I: Sometimes we forget that people like that, they sometimes are very simple-minded and they don't really know. We kind of use jargon, too much jargon, and we scare them to death that way.

Therefore, informants claimed that they are careful in the selection of terminology that they use during discussions with the patient.

Several of the informants also maintained that they attempt to
disseminate information to the patient in a caring and sensitive manner. As one informant stated:

I: A lot of these people have never been in a hospital before....Suddenly they find themselves, technical equipment, lights, buzzers, everything going on. They don't even know what a ... nurse does.

Informants concurred that patients do not require in-depth information to have understanding. Instead, informants claimed that patients require the "basic facts" about what has happened, and the predicted outcome about what is going to happen.

When confirming understanding, informants emphasized that they test the patient's ability to grasp concepts, and the patient's ability to communicate intelligently. As one informant explained,

I: These two patients were both still intelligent ... and alert and they seemed to understand and grasp concepts and could give back a lot of feedback in that they could ... communicate and write and, well, communicate intelligently.

**Testing the Ability to Grasp Concepts**

Several of the informants stated that they test the patient's ability to grasp concepts by chatting with the patient and asking the patient about the information that they had received. Many of the informants claimed that they expect the patient to have a "fairly basic" or a "simple understanding" of the information that has been discussed. One informant recalled the
following example:

I: I think she understood enough about the changes that [her condition] was going to make in her life, without knowing completely what it would be like, to know that that wasn't what she wanted. So I don't think she ... had any idea about just what the entire situation would be, but enough of what she understood she knew that wasn't what she wanted. She knew that she would be hospitalized, that she would not talk again, that she wouldn't eat again.

Informants claimed that intelligence and educational background may influence the patient's ability to grasp concepts.

I: Mr. (Green) is a good example. He was probably late thirties, maybe forty. He was a ... sociologist from the States who was actually Canadian but working down in the States and he was leading ... in his field of Sociology, and he has MS [multiple sclerosis]. And he was in the hospital with pneumonia. And ... he was very intelligent. You ... could just tell. When he wrote a note it was like the real McCoy. I mean he just wrote, ... one day I was talking ... I said, "So, do you smoke?" And he said, "yeah." And he was trached [had a tracheostomy] at the time. Then ... I said, "(Frank), you know smoking's no good for, especially with MS 'cause you can't get up and move around." And then ... I gave him the paper and he wrote that ... "If you do research on it," he said, "you'll find out that ... smoking ... stops the MS from flaring up so much because it takes your stress away."

However, informants maintained that both intelligence and educational background are not significant factors in determining whether a patient has the ability for decision making. For example:

I: I think ... you can make a decision on your life whether you chose to live or die and ... have a Grade Two.

I: I think I sort of have to go from a level that they have a right, even
if they’re dumber than dirt, they have a right to decide their own care.

Informants claimed that what is more important is that the patient needs to be mentally able "to understand the significance of the questions" that are being put to him or her. Several informants stated that they often emphasize the significance of the information that is being presented to the patient by using "flat out terms". As one informant stated,

I: I am not adverse to saying to people, flat out, "If you don’t do this you will die." I think if you don’t tell them in ... flat out terms they may not understand. You can’t couch it in nice language. You have to ... just tell them.

In testing the patient’s ability to grasp concepts, informants stated that they also consider the patient’s familiarity with the information. As in the following example, informants claimed that patients who have had previous exposure to the information may appreciate the significance of the information that they are being asked to consider.

I: But the patient definitely knew after ... having an endotracheal tube down, he didn’t want it again. And he knew after being defibrillated twice that he didn’t want that to happen either.

R: So he knew from experience?

I: Yeah. That it was not something he wanted to repeat.

However, informants also stated that patients that have had no prior exposure to the information may have difficulty understanding the significance
of the information that they are considering. For example, one informant described the following scenario:

I: A new burn patient that comes in, usually they don't feel any pain. Let's say they're third degree, 95%. They are with it. And ... they know what's going on, but they don't feel any pain so they have a hard time understanding that they're not going to live....If they [doctors] talk to them and say, "I'm sorry. We can't do anything more for you." They have a tough time with this because they don't feel any pain so they can't understand.

Another informant concluded that it may be difficult for the patient to "perceive the reality" of what it would be like to be partially paralyzed and wheelchair bound, without prior experience of such an occurrence.

I: Well, if you've never known anybody that was a hemi [hemiplegic] or ... in a wheelchair, then it's very difficult, I think, to perceive the reality of that situation.

In testing the patient's ability to grasp concepts, informants said that they also determine whether the patient understands the consequences of his or her decisions. All of the informants stated that they attempt to discuss with patients the consequences of the decisions that they have made. For example, one informant stated that she has discussed the consequences of bedsores and prolonged recovery with several patients who have refused to turn in bed. Following a discussion of the consequences, informants stated that they look for confirmation of understanding.

Many of the informants stated that they need to be "convinced" that
the patient has an understanding of the information received. One informant described a situation where a patient was to receive a chest tube and consented to the placement of the tube following a discussion with the doctor. However, when the doctor left, the informant was not "convinced" that the patient really understood what was to take place. Factors that cued the informant to the patient's lack of understanding were the patient's off-handed, carefree responses. In addition, the informant felt that the patient was embarrassed to say that he did not understand. Following further discussion of the placement of the chest tube, the informant stated that the patient was shocked to learn of the size of the tube that was to be inserted and the length of time it was to remain in place.

**Testing the Ability to Communicate Intelligently**

When confirming understanding, informants claimed that they also test the patient's ability to communicate intelligently. Many of the informants stated that some patients respond with a "yes" to everything. In the following example, an informant explained why some patients seem to respond with a "yes" to most questions.

I: 'Cause sometimes people just nod "yes" to everything. The socially desirable response.

Several informants claimed that they test the patient's ability to communicate intelligently by asking questions that require a "no" response.
I: So I try and see if you can make them say "no." And if I can make them say "no," but they still answer "yes" to a question, then I think that they ... have some grasp of what I'm asking. If they ask ... if they say "yes" to everything, I then assume that they don't really understand what I'm saying.

I: I mean somebody can always nod "yes." But if you say, "Do you know where you are?" And they nod "yes." "Are you at the zoo?" And they nod "yes". Then I kind of question how much they understand....I don't always ask a question that'll be that "yes" response.

A number of the informants explained that they use eye contact as an indicator of the patient's ability to communicate intelligently.

I: I want eye contact when they look at me and say "yes" or "no."

I: I mean she looked right at you....She ... answered questions ... consistently. She had tears running out of her eyes. I mean it was obvious that she understood the consequences.

I: Sometimes you can get an idea because ... the physician will be explaining things and all of a sudden they'll look over at you ... "I think I'm lost here," type of thing.

Informants also said that the patient that "focuses" and "appears to listen" when spoken to, often has understanding of what is being said.

I: And this gentleman did that. The whole time we were talking to him, he looked at you. I mean, and he was listening to what you were saying. At no point did he sort of look around over her and bring his arm up or anything.

I: You can just look at their face and know that they're not hearing anything that you've said. And other people ... you can tell from their facial expressions and their eyes, and if they're following you or they're looking at you or they're, I mean the face is a good way.
Several informants claimed that the patient who appears to be "drifting" is often unable to focus and concentrate on the conversation, and as a result, lacks understanding of what was said.

Informants stated that they prefer verbal or written forms of communication when testing the patient's ability to communicate intelligently. Some informants felt that other forms of communication may provide only limited indication of understanding.

I: They can never tell you in depth but they can give you an idea.

I: You might say to somebody, "Okay, well ... do you know where you are?" And they could nod "yes." Well, what does that tell you?

Several of the informants stated that when testing the patient's ability to communicate intelligently they consider the clarity of the note that the patient writes and the type of questions that the patient asks. For example:

I: What they ask me, the kind of questions they ask me, the kind of questions they ask the doctor ... things like that ... show me competence.

I: Just how they write the note, and ... it's the words, and ... the questions they ask, if they're pertinent. Like ... how long they're going to be in weaning and that kind of thing, and how long it's going to take and what's expected of them.

In addition, several informants remarked that they also consider the patient's "tenacity" in communicating a choice. Informants described the following examples:
I: He was very strong when he said "Yes, I do."...And I think I would have felt ... wrong in ... not ... giving him treatment.

I: She was still intubated and didn’t care for it, thank you very much, but wasn’t yanking at her tubes, per se, and seemed to be very strong in ... what she wanted to have happen.

I: This lady was very, very determined that she was not having discomfort.

**Validating Responses**

Validating responses is a second strategy that the nurse employs when testing the patient’s abilities for competency in decision making. When validating responses, the nurse considers the patient’s ability to respond consistently, appropriately, and logically. For instance, all of the informants stated that they check for a "pattern of consistency" of response over time.

I: I need consistency. In ... even just simple things, I need them to be consistent in their response to me....That tells me a lot.

I: And in our unit I wouldn’t ... feel confident saying that someone was able to make a decision necessarily in one day. Because it’s that consistency thing. I’d check it out the next day.

To test for consistency, informants stated that they repeatedly ask the patient the same question over a period of time. Informants recounted the following examples of consistency in responses over time:

I: You know when you ask her questions, sometimes ... she’s in the hospital, sometimes she’s at the home....Sometimes she’s at her old house. And she [a nurse] said, "She’s not consistent with her nods and ... her shaking of her head."
I: She wasn’t consistent. She’d say, "Yes, I want to die," and then all of a sudden, she’d be like, "No, no, I can’t. Don’t pull my trach [tracheostomy]." Or whatever we were going to do. "Don’t put me on the morphine. I don’t want to die yet. I’m not ready."

Many informants claimed that a consistent response over time often indicates competency.

I: I thought he was competent to continue to say the same thing.

Several informants stated that they look for consistency between the patient’s behavioural and physiological responses. As one informant recounted:

I: She would say she wanted to ... die but then she was ... very tachycardic and her breathing was way out of whack. And you’re like, "Are you scared about this?" And she’d be, "Yeah." I said, "Well, are you sure you really want to do it?" She’d say, "No, I’m not sure yet."

A few informants stated that they also look for consistency between the patient’s verbal and physical responses. For example, one informant stated,

I: Like sometimes if you say, "Are you having pain?" And they say "yes." And then they drift off to sleep, let’s say, over and over again. Or if I say ... "Do you know where you are?" "Yes." And ... then ... I say, "Where are you?" and they don’t respond. Or ... "Would you like to turn?" And then, "yes" or something. And we turn and they’re resisting.

When testing the patient’s competency, many of the informants stated that they consider whether the patient’s responses are appropriate. One informant described the following "appropriate" responses:

I: People that roll their eyes or people that try and smile. Or ... they’ll try and spell out letters with their fingers.
Things like that to me show competence. They're there, and they're responding appropriately to what I'm [saying] ... or trying to respond appropriately to what I'm asking.

Another informant described, as an example of an inappropriate response, the patient who attempts to get out of bed following an explanation of why he or she must remain in bed. Several informants stated that they test whether the patient's verbal responses are appropriate when assessing the patient's level of consciousness. For example, informants stated that they test the patient for orientation to person, place, and time.

Informants also stated that when testing the patient's abilities for competency in decision making, they also consider whether the patient's responses are logical or "make sense." Several informants inferred that a "logical" response is one that they consider "rational" and "reasonable," considering the circumstances. Informants gave the following examples of "logical responses."

I: So I said to him, "... if we don't do this ... you're probably going to die." And he said, "I'm an old man." I mean, to me, that was ... the logical conclusion to come to. "I'm an old man and maybe it's my time to die."

I: She gave reasonable answers to questions. There ... was no flight of ideas, or ... she was just very logical.

I: If we take the circumstance of an elderly person, say in their 80s, now I don't know what I would do, but I ... use the term "logically" to say that if somebody says to me, "I'm 80 years old, I've lived my life. I ... now I'm going to die. This seems to be my time." Now
that's what I call logical. I don't know if that's how I'll feel when 80 years old. But, from my perspective ... that's seems ... I can accept that.

R: Ok, ... but that wouldn't be "logical" if someone who was 40 was saying that?

I: Well, ... now again it would depend on the circumstances. If it was somebody who was 40 and basically healthy, no, I wouldn't think it was logical. But if it was somebody who was 40 with a chronic illness, who had ... not a very promising future in terms of quality of living, no, I might think that was logical, too.

Deciding

Informants who had completed the four stages of the process of decision making for competency determination were generally comfortable in defending their decisions regarding patient competency. When informants were asked what they did with these determinations of competency, responses were varied. Several of the informants claimed that they consult with competent patients "about anything" that is being done to them, including "small," "basic," or "simple" things, such as "getting up out of bed," "turning," and "having visitors," as well as about more complex issues, including the "medications" that they are receiving and the management of their "pain."

Many of the informants stated that on occasion competent patients choose not to make their own decisions. As one informant stated, in some cases patients "just want the doctor to take ... their hands and make that decision for them." Informants concurred that they support the choices of
competent patients who "don't want to be responsible for their own decisions."

Some of the informants stated that frequently choices about "those little decisions, those day-to-day things" are taken away from the critically ill patient. As one informant explained, "It's just the nature of the unit."

One of the informants claimed that competency determination in the ICU is not an "issue unless the risk factors are at a high level and the invasive procedures are life-threatening." Another informant basically concurred:

I: The more serious the invasive procedures, then ... the more important the competency is.

Other informants stated that they often "override" competent patients' decisions in a "cruel-to-be-kind" way. For example, these informants explained that they may make the patient "get up in a chair when they don't feel like it," or they may give a patient an "enema against their wishes."

Informants explained that they do this because these interventions are not "life-threatening," and are "actually aiding" the patient "to get better." As one informant explained,

I: I ... draw the line as far as respecting people's wishes when they are opposed to what I think is best for them....Because I think there's an awful lot of circumstances where what the person in the bed feels is good for them isn't medically good for them. It might improve their humour or their outlook on life, or it might make them feel better for the moment but it isn't going
to be beneficial for them in the long run. And ... I think my whole nursing practice ... is doing that, either trying to convince them of another way or getting very firm with them if they aren't going to do it my way. I ... know that sounds quite autocratic but ... I believe a lot of nursing is about this, especially critical care type of stuff.

A few informants said that they rarely ask patients for permission prior to implementing care. One informant said,

I: I might explain what I'm going to do but I don't ask permission a lot.

As a result, for these informants the practice of respecting patient autonomy in the Intensive Care Unit is varied. A determination of patient competency does not always result in the inclusion of the patient in decision making.

Summary

This chapter considered the process of decision making that nurses use to determine whether critically ill individuals are competent to consent to treatment (Figure 3). The process of decision making is comprised of four stages, each of which is characterized by particular conditions, properties, strategies, and consequences. The way in which each informant completed the stages of the process is varied. However, a common thread linking the informants in the process is the core category, knowing the patient. Knowing the patient is a complex cognitive process aimed at determining patient competency. It involves the integration of three types of knowing: knowing
the patient's illness, knowing the patient's responses, and knowing the patient as a person. It ultimately provides the foundation for testing the patient's abilities for competency in decision making. The completion of all four stages of the process can result in a determination of competency. However, in the end, for these informants, the need to complete and act on such a determination is individual.
RECEIVING THE PATIENT
"Knowing the Patient's Illness"

Assimilating Information
Initiating the Relationship
Securing Communication

ANALYZING THE DATA
"Knowing the Patient's Responses"  HUMANIZING THE PATIENT
"Knowing the Patient as a Person"

Assessing Awareness
"Knowing the Patient"

Examining Emotional States

TESTING ABILITIES
Confirming Understanding
Validating Responses

-Disseminating Information
-Testing the Ability:
  -to respond consistently
  -to respond appropriately
  -to respond logically

-to grasp concepts
to communicate intelligently

DECIDING

Figure 3. The Process of Decision Making for Competency Determination
CHAPTER V: DISCUSSION

In this final chapter, several aspects of the study are addressed. In the first portion of the chapter, the research methods used in the study are described. Following that, the major findings of the study are discussed in relation to the literature that pertains to the process of decision making for competency determination. Within this discussion, implications for nursing practice and research are drawn.

Discussion of Research Methods

Grounded theory is the qualitative approach used in this investigation. It provided a means of ascertaining the process of decision making that nurses use for making determinations of patient competency. Sandelowski (1986) discusses four criteria of rigor for qualitative inquiry: truth value, generalizability, neutrality, and replicability. The strategies used to achieve rigor in this study are discussed in relation to each of these criteria.

Truth Value

"The truth value of a qualitative investigation generally resides in the discovery of human phenomena or experiences as they are lived and perceived by subjects" (Sandelowski, 1986, p. 30). Thus, the truth value of a qualitative investigation is subject-oriented rather than researcher-defined. In
the present study, the truth value resided in the discovery of the core category, *knowing the patient*, as perceived by the informants. The core category emerged early in the data analysis as the informants repeatedly alluded to how their expanding knowledge of the patient provided the foundation for their decisions of competency. Many of the informants gave impassioned examples of patients whom they claimed were competent. Informants explained that they "knew" these patients, and as a result were certain of their competency.

Sandelowski (1986) cautions that the truth value of qualitative research can be threatened by the closeness of the investigator-subject relationship. The investigator may be unable to maintain the necessary distance from the subjects' experiences to describe them in a meaningful way. In the present study, the interviews were by nature interactive. However, the use of theoretical sampling and the continuous, comparative analysis of the data assisted the researcher with the identification of distortions and inaccuracies in the developing theory. This limited the potential effect of the researcher in the study.

Sandelowski's (1986) view is that the truth value of qualitative research should be evaluated against a criterion of credibility. She explains that a study is "credible when it presents such faithful descriptions or interpretations
of a human experience that the people having the experience would immediately recognize it from those descriptions or interpretations as their own" (Sandelowski, 1986, p. 30). In the present study, select informants provided validation of the major aspects of the resultant theory, which emerged from the data, thus testing the credibility of the findings.

**Generalizability**

Sandelowski (1986) states that in qualitative research, generalizability may be something of an illusion. That is because each research situation ultimately involves a particular researcher in interaction with a particular subject in a particular context. However, Sandelowski (1986) also identifies strategies to enhance generalizability in qualitative inquiry, such as determining the typicality of the informants' responses and establishing the position or weight of each informant's "story" in relation to the group's understanding. In the present study, atypical experiences were investigated to help describe the phenomena as richly and accurately as possible. An example was the use of the patient's first name in the initiation of the nurse-patient relationship. As well, theoretical sampling allowed the researcher to pursue "hunches," address specific questions, expand certain points, and confirm or refute emerging hypotheses. For instance, the researcher investigated the following hypothesis that emerged from the data: the family
is a significant factor in the nurses' assessment of patient competency. Informants emphasized that their observations of patient and family interactions, and their own discussions with patients' families, provided valuable data to be considered as they came to know their patients. As a result, theoretical sampling assisted the researcher in establishing the weight of each informant's "story" in relation to that of the groups. Consequently, the findings reflect a combined understanding of the process of decision making of competency determination as opposed to an understanding of any one individual.

Sandelowski (1986) further states that the generalizability of qualitative research should be evaluated against a criterion of "fittingness" (p. 32). In other words, the research findings may be generalizable when they "fit" the data from which they are derived, and when they "fit" into contexts outside the study situation from which they originate. The findings of the present study firstly are grounded in the data. In each stage of the process, conditions, properties, strategies, and consequences of the categories and subcategories were identified from the data. For example, "understanding" the consequences of a decision was identified as a condition of competency by the informants, and testing the patient's ability to grasp concepts was identified as a strategy for "confirming understanding" in stage three of the
process. Each finding in the study was derived from the data and checked against the data for "fit".

In terms of a "fit" with contexts outside the study, the findings of the present study may "fit" with other populations, such as nurses caring for geriatric or mental health patients who participate in decision making about their life and health. Determining competency in these patient groups may in fact require a process similar to the one found in the present study.

Neutrality

Neutrality refers to freedom from bias in the research process and product (Sandelowski, 1986). In the present study, the possibility of the researcher having imposed her own bias on the responses of the informants must be acknowledged. The researcher is a critical care nurse. That may, in itself, have introduced a perspective or bias in the interpretation of the data. As well, the researcher was familiar with some of the informants prior to interviewing them. However, it may also be that the prior knowledge of the researcher and the previous interaction with some of the informants may have enabled the informants to express their ideas with greater candor and ease. As Sandelowski (1986) states, "Paradoxically, the closeness of the investigator-subject relationship both enhances and threatens the truth value of a qualitative study" (p. 34). The present study is an example. The
closeness of the researcher and the informants may have enhanced, as well as threatened, the validity of findings.

Sandelowski further suggests that confirmability is a criterion on which neutrality is evaluated. In the present study, the findings were confirmed by select informants in an effort to establish rigor in the research. As Sandelowski (1986) states, "Confirmability [and thus neutrality] is achieved when auditability, truth value, and applicability are established" (p. 33).

**Replicability**

Sandelowski (1986) states that in qualitative research, replicability is evaluated by a criterion of auditability. Auditability means that another researcher would be able to follow the progression of events in a study and understand its logic. In the present study, the decision trail or progression of events is described, including the background to the problem, the research question, the purpose of the study, the data collection and analysis procedures, and the strategies used to determine the truth value and generalizability of the findings. As discussed earlier, it may be useful to evaluate the auditability of the findings in the present study through researching the process of decision making used by nurses for competency determination with the same group using similar conditions.
Summary of Findings

In the present study, the researcher investigated the process of decision making that nurses use for determining whether critically ill patients are competent to consent to treatment. The findings of the study reveal a process of decision making for determining patient competency that is largely subconscious and unknown to the nurse. The process consists of four stages: receiving the patient, analyzing the data, "humanizing" the patient, and testing the abilities of the patient.

The process was discovered in the analysis of the informants' stories of patients whom they claimed were competent. Informants were asked to trace their steps and to explain how they came to their conclusions of competency. The resulting findings indicate that through the course of patient care, nurses acquire considerable knowledge and understanding of their patients. Nurses make competency determinations in varied ways. However, the common thread in the process is that nurses come to "know" their patients prior to making decisions about their competency.

Knowing the patient refers to the cognitive changes that occur in the nurse from the time the nurse first receives the patient to the time the nurse reaches a decision about the patient's competency. The findings indicate that knowing the patient involves three areas of understanding: knowing the
patient’s illness, knowing the patient’s responses, and knowing the patient as a person. Nurses acquire these three types of understanding through both objective and subjective means. For example, the nurse may perform a head-to-toe physical examination of the patient and acquire objective knowledge about the patient’s illness. At the same time, the nurse may evaluate a particular patient’s response and subjectively interpret the meaning of that response.

Knowing the patient provides the foundation for testing the patient’s abilities for decision making. Testing the patient’s decision making abilities includes confirming the patient’s understanding of information relevant to a decision, as well as assessing whether the patient’s responses are logical, appropriate, and consistent over time.

Completion of the four stages of the decision making process places the nurse in a position to make a clinical judgment about the patient’s competency. However, a decision that a patient is competent does not always guarantee the patient’s involvement in decision making. In a somewhat surprising result, the findings show that even after determining a patient to be competent, using this subconscious, but shared process, nurses may not include the patient in decision making, and/or may not follow the patient’s own decisions regarding the care to be given.
There are four major findings in the study:

1. the process of decision making used by nurses for competency determination is subconscious in nature,

2. nurses come to know their patients both objectively and subjectively prior to a determination of patient competency,

3. knowing the patient provides the foundation for testing the patient’s thought processes and abilities for competency in decision making, and

4. a decision of competency does not always result in the inclusion of the patient in decision making.

Relation of the Study Findings to the Literature

In general, the literature on competency determination almost exclusively focuses on a specific examination of the patient’s mental status and decision making abilities (Appelbaum & Grisso, 1988; Drane, 1984; Folstein et al., 1975; Janofsky et al., 1992; Roth et al., 1977). Such an examination is usually completed by an outside consultant, typically a physician (Miller, 1989).

In contrast, the findings in the present study indicate that while the nurse makes a similar determination of competency, he or she does so in a different manner. That different manner is uniquely related to the role of the nurse in the care of the patient. In contrast to an outside consultant, the nurse is the key person responsible for providing direct and continuous care to the patient. The nurse thus forms a relationship with the patient, and
through that relationship seeks to create an atmosphere of trust. As a result, the patient is often willing to express, with greater candor, his or her personal needs, concerns, and views to the nurse. If this occurs, it makes the nurse privy to information not easily obtained by an individual not as well known to the patient.

It is on the basis of this direct contact, and consequent understanding of the patient, that the nurse comes to "know" the patient. The nurse draws from that knowledge when assessing the patient's abilities for decision making. For example, being able to appreciate the patient's perspective of a given situation assists the nurse in validating the logic behind the patient's decision.

This approach to competency determination by the nurse stands in contrast to the approach described in the literature, as noted above. One exception is the work of Jurchak (1990), who refers to two types of competence: legal competence and clinical competence. Jurchak claims that there is a similarity between the formal competency assessments that are court and physician determined, and the informal competency determinations that are made in the context of a set of relationships, such as the nurse-patient relationship.

In considering the study's major findings in relation to the literature, it
was found that the literature on clinical decision making is helpful in addressing the nursing determination of critically ill patient competency. The concepts in that literature often support, or are at least relevant to, the findings in the present study regarding the nurse's approach to competency determination.

The "Subconscious" Nature of the Process

To date, there is no literature specifically describing how nurses make decisions about patient competency for consent to treatment. The sparse literature that does exist describes the nurse's contribution towards competency determination as merely an assistant to others who perform structured, formal competency assessments (Fry, 1987).

However, the findings of the present study indicate that nurses do determine patient competency, but do so in a nondeliberate way. More specifically, the process that nurses use for competency determination is largely subconscious in nature, and unknown to the nurse. This was concluded because informants in the study had difficulty articulating the way in which they arrived at their decisions of competency, however, when probed, were able to identify numerous factors that they considered when determining patient competency.

Although the subconscious processes used in competency
determination have not been described elsewhere, a large body of literature exists regarding the use of intuitive processes in clinical decision making. For example, in studying intuition and expert maternal-child nursing practice, Schraeder and Fischer (1986) found that some nurses working in labor and delivery were able to predict the need for a mother to have a caesarean section early in labor, when the empirical data were not pointing clearly to this intervention. Consequently, Schraeder and Fischer described intuition as immediately knowing something without consciously using one’s reasoning skills. Similarly, the findings of the present study show that nurses make claims regarding patient competency determination, but generally are not conscious of their reasoning, and consequently have difficulty explaining their decisions.

The significance of this finding is that nurses do not apply formal, objective tests of competency determination to their patients, as described in the competency literature. Instead, nurses arrive at decisions of patient competency as they come to know their patients through the course of patient care. However, because of the extreme importance of competency determination, there needs to be further inquiry into this subconscious process. While the subconscious approach to determining competency appears to be an integral part of the process used by nurses, it may be
subject to skepticism and even criticism without further study and validation.
Making determinations of patient competency without being able to articulate
why may not convince others of the accuracy of such a finding, and may
result in doubt and uncertainty. Further study may serve to identify the
components of what is now perceived to be a subconscious process, thereby
potentially assisting in legitimizing this aspect of how nurses come to know
their patients before making decisions about their competency.

Knowing the Patient

As already noted, the literature relevant to competency determination
tends to be medically based, and focuses on discrete assessments of the
patient’s mental status and decision making abilities (Appelbaum & Grisso,
1988; Folstein et al., 1975; Janofsky et al., 1992; Roth et al., 1977; Silberfeld,
1991a). The assessment is commonly performed by an outside consultant,
typically a physician, who usually has no prior knowledge of the patient
(Elliot, 1991). The assessments are objective tests of mental capacity that the
physician administers to the patient.

The findings of the present study indicate that nurses also consider the
patient’s cognitive functioning, but do so only after acquiring an in-depth
understanding of the patient. In respect to the literature, authors (with the
possible exception of Jurchak, 1990) have not addressed how nurses come to
know their patients in order to make decisions about patient competency. Knowing the patient has, however, been described in relation to clinical practice. Tanner, Benner, Chesla and Gordon (1993), in studying the development of expertise in critical care nursing practice, found that knowing the patient is central to skilled clinical judgment. In that the determination of patient competency can be seen as a clinical judgment, this is consistent with the findings of the present study.

Tanner et al. (1993) found that knowing the patient involves two types of knowing; namely, knowing the patient’s typical pattern of responses and knowing the patient as a person. The findings in the present investigation differ slightly from the findings of Tanner et al. in that the informants indicated that knowing the patient involves three types of knowing: knowing the patient’s illness, knowing the patient’s responses, and knowing the patient as a person. Thus, the findings in the present study add a third kind of knowing to that described by Tanner et al.; namely, knowing the patient’s illness.

In general, a nurses’s knowledge of the critically ill patient begins with an understanding of the patient’s illness. As well, a patient’s responses are usually related to his or her illness. It may not be a large step to see knowing the patient’s illness as being inferred in knowing the patient’s typical pattern.
of responses. Accordingly, Tanner et al.'s work on knowing the patient may be supportive of the findings in the present study of knowing the patient in the particular context of making a competency determination.

In the present study, knowing the patient was found to incorporate both formal and informal means of knowledge acquisition. Tanner (1987) found that nurses acquire facts about patients' illnesses through formal assessments. The findings of the present study are partially supported by Tanner, in that nursing based competency determinations include formal bases for knowing the patient as nurses come to know their patients through formalized reports and physical examinations.

Tanner et al. (1993) state that these formal assessments provide nurses with "explicit, decontextualized data-based knowledge" (p. 273). However, Tanner et al. go on to describe knowing the patient as an "immediate grasp, an involved, rather than detached understanding of the patient's situation and patient's responses, an understanding that is directly apprehended, and that may remain largely ineffable" (p. 275). Therefore, according to Tanner et al., knowing the patient differs from formal knowledge acquisition. Thus, the findings of the present study are also partially supported by Tanner et al. in that nursing based competency determinations include informal bases for knowing the patient as nurses come to know their patients through their
previous experience with similar cases and through their intuition.

**Formal Means of "Knowing"**

The findings in the present study indicate that in the first stage of the decision making process, objective knowledge of the patient's illness is acquired through a formalized report about the patient called "handover." The informants believed that knowing the patient's illness helps them to anticipate possible patient outcomes and responses. By anticipating patient outcomes and responses, nurses are thus able to develop an understanding of how ill the patient is, and of the likelihood that the patient will be able to participate in decision making.

Jurchak (1990) states that factors such as temporary, reactive depression resulting from an unexpected diagnosis, or the side effects of medications, can affect the patient's capacity for decision making. Informants in the present study also identified factors such as sepsis, a decreased level of consciousness, age, medications, and emotional states that they objectively observe and analyze in regard to their effects on the patient's capacity for decision making. For example, when informants considered the effects of emotional states on patients' responses, they often believed they were able to identify when patients' emotions were influencing their choices. In the present study and consistent with Jurchak (1990), it was found that factual,
objective, formal means of knowing assist the nurse in coming to know the patient for the purpose of determining patient capacity for decision making.

**Informal Means of "Knowing"**

The use of informal means of knowing has been described elsewhere. For example, Lutzen and Nordin (1993), in studying the experience of moral decision making in psychiatric nursing practice, found that "knowing" was one of three interrelated processes for structuring moral meaning. They described "knowing" as a non-linear, subjective way of understanding the moral meaning of the nurse-patient relationship after perceiving a moral conflict. They also stated that "knowing" was an indirect way of arriving at a decision. Similarly, informants in the present investigation used subjective means of knowing, such as experiential knowledge and intuition, to assist them in making decisions of patient competency.

**Experiential "Knowing"**

In the present investigation, the informants relied on their previous experience with similar cases to assist in the interpretation of information received about the patient's illness. They also used experiential knowledge as a basis for creating a set of expectations about the patient. This set of expectations provided the informants with a perspective from which to begin to understand the patient in his or her state of illness.
Benner, Tanner, and Chesla (1992), in studying the nature of skill acquisition in nursing practice, found that experience or experiential learning was one of three notions central to the practical knowledge exhibited in expert nursing practice. Experiential knowledge is described as private subjective accountings of what has been learned in practice (Benner et al., 1992). The nurse learns directly from experiencing the "varieties of natural courses of events associated with illness, disease, recovery, birth, and death" (Benner et al., 1992, p. 27). Thus, the Benner et al. study supports the idea of nurse's experience based knowing in competency determination of the critically ill individual.

**Intuition**

The place of intuition in nursing practice has been the subject of numerous investigations (Agan, 1987; Benner & Tanner, 1987; Rew, 1990; Schraeder & Fischer, 1987; Young, 1987). The focus of nursing education has traditionally emphasized nursing as both a science and an art. Clark (1990) states that nursing science focuses on process and factual data, while nursing as an art is thought to be based in individuality and feeling. In reference to the art of nursing, Gerrity (1987) refers to intuitive knowledge and describes it as a perceptual process used by nurses in clinical decision making. Similarly, informants in the present study claimed that their
knowledge of their patient's competency was often, in part, intuitive. They understood intuition as knowing something when there is no proof.

While Clark (1990) argues that intuitive knowledge is largely misunderstood and undervalued by most professions, including nursing, informants in the present study did not appear to either misunderstand or undervalue their intuitive knowledge of patients. They claimed that they often use intuition when assessing awareness in order to enhance their knowledge of patients' responses. The role and value of intuition in competency determination consequently may be a prime area in which to further study the role of intuition in clinical decision making in general.

Knowing Through the Nurse-Patient Relationship

Several authors have put forward the general position that a true competency assessment requires the formation of a relationship with the patient (Fowler, 1989; Jurchak, 1990; Varricchio et al., 1993). Jurchak (1990) states that nurses who "listen" to their patients come to know their patients. Macklin (1987) claims that people who speak brusquely, who are hurried in their communications, or who are evasive in their answers, are less likely to be trusted or to instill confidence than those who take time to explain things, and especially, to listen. The findings in the present study on competency determination by nurses are consistent with these comments in the general
nursing literature on knowing the patient. Similarly, informants in the present study described how they established relationships with their patients through strategies of chatting, listening, and sharing.

The findings of the present investigation indicate that it was through the development of a personal relationship with the patient that the informants believed that they gained valuable information about the patient as a person. For example, when "humanizing the patient", informants gained insight into the patient's understanding of his or her illness, as well as insight into what the illness means to the patient as a person. In essence, the informants began to understand the patient's situation from the patient's perspective. Jurchak (1990) emphasizes that this type of knowing is different than knowing the patient's "numbers" (p. 457) and anticipating the patient's medical needs. It is a willingness to learn how the patient experiences events occurring to and around him or her. Similarly, Swanson (1991) describes this type of "knowing" as understanding the meaning of an event in the life of another. As shown in the present investigation, such an understanding helps the nurse appreciate the impetus and reasoning behind the patient's decisions. As Jurchak (1990) states, the nurse often learns information about a patient that is "the missing puzzle piece that reveals that a bizarre decision or response is rational" (p. 458) in the circumstances of that patient.
Trust is also an essential component of the nurse-patient relationship. Washington (1990) argues that trust can be developed through therapeutic touch, honesty, and a portrayal of confidence. The informants of this study provided numerous examples of how they used touch and projected attitudes of competency and honesty in dealing with their patients. This formed an essential part of how they came to know the patient through the relationship which developed.

**Knowing Through The Identification of Patient Values**

Fowler (1989) and Varricchio et al. (1993) posit that a true competency assessment requires a familiarity with the individual's personal values. Jurchak (1990) states that the sense of "caring" that is conveyed through the nurse-patient relationship is communicated to the patient by the nurse’s ability and willingness to meet the patient where he or she is, and to come to know the patient and his or her values from the patient’s perspective. In the present investigation, informants gained considerable insight into the patient as a person though discerning the patient’s values. Thus there is evidence in both the literature and in this study that discerning the patient’s values helps the nurse understand the patient’s behaviors and appreciate the patient’s decisions.
Testing Decision Making Abilities

The findings of the present study demonstrate that as the nurse comes to know the patient, the nurse acquires an understanding of the person as a whole. Once this understanding is acquired, the nurse is in a position to examine the patient's decision making abilities.

Fowler (1989) and Varricchio et al. (1993) contend that a true competency assessment requires familiarity with the individual's decision making abilities. The findings of the present investigation are congruent with these authors' claims in that the testing of the patient's mental abilities is essential in determining patient competency. However, the present study findings also conclude that an examination of the patient's mental status and decision making abilities is only one part of competency determination.

Jurchak (1990) points out that the mental status examination in psychiatry is a systematic evaluation of key aspects of a patient's psychological state. It includes questions that test cognitive ability, memory, and judgment. It also assesses the emotional tone of the patient. In the present investigation, informants indicated that they also considered these aspects of the patient. For example, in stage two of the process, informants assessed the patient's memory and emotional status. In stage three of the process, the nurse focuses on testing the patient's ability to understand information, to
communicate intelligently, and to respond consistently in a reasonable, rational and logical manner.

Jurchak (1990) claims that, in the intensive care setting, it is often presumed that patients do not have an opinion or are incapable of either understanding choices or expressing them. This is because of the severity of their illnesses and of the interference of equipment with the usual avenues of communication. In contrast to Jurchak, this investigator discovered that informants believed they were able to assess the effect of the patient's illness and the environment on the patient's responses, and were often able to work around barriers of communication and technology.

While Miller (1989) is of the position that medicine holds primary responsibility for determining patient competency for consent to treatment in the clinical setting, others argue that there are a number of limitations and inconsistencies in how patient competency is currently being determined (Appelbaum & Roth, 1981; Elliot, 1991; Farnsworth, 1990; Silberfeld, 1991a; Silberfeld & Checkland, 1993). The findings of the present investigation indicate that the nurse's knowledge and understanding of the critically ill patient place the nurse in a unique position, and perhaps in an optimal position, for determining patient competency. Knowing the patient's illness and the patient's understanding of the illness; knowing the patient's responses
to the illness and the environment; knowing the patient's beliefs, values and wishes; and knowing the patient's abilities for understanding information and communicating choices provide a foundation upon which to evaluate and respect the patient's autonomy in decision making.

**Responding to Decisions of Competency**

A somewhat surprising and intriguing finding in the present investigation is that, despite a determination of competency, the informants did not always follow the wishes of their competent patients. Numerous authors of ethics and nursing have stressed that there is agreement among nurses that a competent patient's wishes for treatment ought to be respected (Canadian Nurses Association, 1991; Fowler, 1989; Fry, 1987; Jurchak, 1990; Wiens, 1993; Varricchio et al., 1993). Nevertheless, in the present investigation, some informants spoke freely of how they often "override" competent patients' decisions; in effect using the principles of beneficence and nonmaleficence as justification. In addition, some of the informants believed that competency determination in the intensive care unit is not really an issue unless the treatment to be implemented is life threatening.

The nurse-patient relationship is relevant to the issue of patient competency in respect to both patient self-determination and patient advocacy (Jurchak, 1990). Jurchak believes that the nurse is pivotal in
balancing the rights of patient autonomy with the health care team’s ethical obligation to avoid harm and to do good. Jurchak states that, in the intensive care setting, the crystal clear directive of respecting patient autonomy can become murky in actual practice because of the question of competence and decision making capacity. The findings in the present investigation demonstrate that even a determination of patient competency does not always result in the inclusion of the patient in decision making.

Further research into the nature of intensive care nursing practice and its effect on patient self determination is needed in order to address this finding. Specifically, it may be that the principles of patient autonomy and self-determination, on the one hand, and the principles of beneficence and nonmaleficence, on the other hand, compete. If so, that poses large, significant questions for both nursing theory and practice.

The findings indicate that some of the informants had questioned physicians’ orders that conflicted with the desires of patients they thought competent. This finding is consistent with the nature of the nurse-patient relationship and the concept of patient advocacy noted in the literature. Jurchak (1990), for instance, states that it is the nurse-patient relationship that brings the nurse’s attention to the patient’s point of view. However, Jurchak points out the difficulties in speaking on behalf of the patient,
sometimes as a minority voice and against physician or peer pressure. That, too, presents a challenge for nursing theory and practice. If this role of patient advocate regarding competency is justified and to be countenanced, or even fostered, in practice, it should be validated through further study establishing firmly its premises, principles, and limitations. Only then will it have a solid basis upon which to proceed and to address the difficult questions of not consulting or following a competent patient’s wishes or adopting a role of patient advocate against physician, peer, or family pressure. The present study has served to highlight these issues, but not answer them.

**Conclusion**

The purpose of this study was to investigate the process of decision making that nurses use when determining whether critically ill individuals are competent to consent to treatment. The findings have served to identify a number of issues related to the role of the nurse in relation to the determination of patient competency. It is hoped that the findings of this study will provide a sound basis for future inquiry.
REFERENCES


APPENDIX A

Information Letter for Participants
Information Letter for Participants

**Project Title:** The Process of Decision Making for Competency Determination of the Critically Ill Individual for Consent to Treatment.

**Investigator:** Joan Prociuk, Ph. XXX-XXXX

**Faculty Advisors:** Carol Jillings, R.N., PhD., Associate Professor, Ph. 822-7479  
                Joy Johnson, R.N., PhD., Assistant Professor, Ph. 822-7486

Dear Participant:

I am a Registered Nurse who has worked in Intensive Care Units for the past eleven years. In completing my course work for graduate studies, I am conducting a research study to investigate the decision making process that nurses use for determining whether the critically ill patient is competent to consent to treatment. I am inviting you to participate in this study.

Participation in the study is voluntary. Involvement in the study includes participating in a maximum of three interviews lasting approximately one hour each. As a participant, you will be free to refuse to answer any question without consequence, and may withdraw yourself or any specified data from the study at any time. Each interview will be audiotaped by myself and transcribed. All information will be kept confidential and coded so that your identity will be known only to myself.

Although there is no direct benefit for you in participating in the study, the information that you provide may increase nursing knowledge with respect to the process of competency determination. Thank you for considering to take part in my research study. I can be reached at the above number to answer any questions that you may have about participating in this study.

Yours truly,

Joan Prociuk, R.N., B.S.N., B.A.
APPENDIX B

Participant Consent Form
The University of British Columbia
School of Nursing
T206-2211 Wesbrook Mall
Vancouver, B.C. Canada V6T 2B5

Participant Consent
Tel: (604) 822-7417
Fax: (604) 822-7466

Project Title: The Process of Decision Making for Competency Determination of the Critically Ill Individual for Consent to Treatment.

Investigator: Joan Prociuk, RN, M.S.N. Student

Faculty Advisors: Carol Jillings, R.N., PhD., Associate Professor, Ph. 822-7479
Joy Johnson, R.N., PhD., Assistant Professor, Ph. 822-7486

The purpose of this study is to investigate the process of decision making that nurses use for determining whether the critically ill patient is competent to consent to treatment. Participation in the study is voluntary. Although there is no direct benefit for you in participating in the study, the information that you provide may increase nursing knowledge with respect to the process of competency determination.

Involvement in the study includes participating in a maximum of three audiotaped interviews with the investigator, lasting approximately one hour each. As a participant, you will be free to refuse to answer any question without consequence, and may withdraw yourself or any specified data from the study at any time. Following each interview, field notes will be written by the investigator, and audiotapes will be transcribed. All identifying information on the transcripts and field notes will be deleted and replaced with codes, so that only the investigator will be aware of your identity. The "key" to the codes will be kept in a file in a locked drawer to which only the investigator will have access. At the completion of the study, the "key" to the codes will be destroyed and audiotapes will be erased. The transcripts and field notes will be retained for future teaching and research purposes. There will be no monetary compensation for participating in this study. If you have any questions concerning the study, you may contact the investigator, Joan Prociuk at XXX-XXXX, or either faculty advisor as listed above.

I have read the above information and have had the opportunity to ask questions with respect to my participation in the study.

I, ________________________________, freely consent to participate in the above described study. I acknowledge the receipt of a copy of this consent form.

Signature of the Participant Signature of the Investigator Date
APPENDIX C

Sample Trigger Questions
Sample Trigger Questions

The following are a sample of trigger questions used in this study.

1. Tell me about your experiences of deciding whether critically ill patients can consent to treatment?

2. How do you become familiar with a critically ill patient’s thought processes and values?