Medical Staff’s Decision-Making Process in the Nursing Home

Jiska Cohen-Mansfield and Steven Lipson

1Research Institute on Aging of the Hebrew Home of Greater Washington, Rockville, Maryland.
2George Washington University Medical Center, Washington, D.C.

Background. This paper describes the medical decision-making process at the time of status change events in the nursing home.

Methods. Six male physicians and 3 female nurse practitioners completed questionnaires that described the medical decision-making process for 70 residents of a large nonprofit nursing home.

Results. Hospitalization was the most frequently cited treatment considered and chosen; family members were involved in 39% of decisions, and nurses were involved in 34%. The most important considerations in making a decision were reported to be the resident’s quality of life, the relative effectiveness of the treatment options, and the family’s wishes. The levels of importance ascribed to the considerations were related to the physician’s identity, specific resident characteristics (such as estimated life expectancy), and communication between the physician and resident (such as sharing knowledge of family wishes).

Conclusions. The decision at the time of a status change event involves multiple conditions, multiple considerations, and multiple treatment options, and tends to result in either an active route, such as hospitalization, or a passive one, such as comfort care. The impact of the individual physician and the physician–resident relationship on this process deserves further investigation.

METHODS

Participants were 70 nursing home residents in a large suburban nursing home that employs 5 full-time physicians (due to turnover, 6 were included in the study) and 3 nurse practitioners. Three-quarters of the participants were women, and the average age was 89 years (range 63–102 years). Of the participants, 71.4% were widowed, 14.3% were married, 7.1% were never married, and 7.1% were divorced or living separately. The mean Minimum Data Set Cognition Scale (MDS-COGS) score (1) was 5.1, with a range of 0 to 10 (higher score indicating greater impairment). Of the 70 participants, 10 died before data collection. To be eligible for the study, a participant had to have experienced an event that changed his or her medical status. A status change event was defined as a health-related change that was either a significant change on the MDS, a nonchronic condition that called for medical follow-up by a physician, or a dying process that called for a medical decision involving the formal caregivers. In addition, we chose those events in which the resident was not cognitively able at the time of the status change event to make his or her own decisions, or, in the case of death, the resident must have had a medical decision made within a day or two of his or her death.

An interview ascertained the physician’s personal opinion regarding a range of questions relating to the status change event and the decision-making process. Three of the six physicians completed nine questionnaires each (12.9%), and the three other physicians completed 1 (1.4%), 13 (18.6%), and 24 (34.3%) questionnaires, respectively. Two of the nurse practitioners completed one questionnaire each (1.4%), and the third completed three questionnaires (4.3%).
questionnaire contained both open- and close-ended questions in five general areas (Table 1 and Appendix 1). It included both quantitative and qualitative portions (2). A research staff member usually contacted the physician the day after the status change event, when the event appeared on internal nursing home reports. The actual time of the interview varied from that same day to several days later. Based on the questionnaire results, we calculated the number of passive treatments (e.g., comfort care) considered and chosen as well as the number of active treatments (e.g., medication, hospitalization) considered and chosen. This study was approved by our institutional review board.

We postulated several hypotheses to examine the relationships among process and outcome variables, as follows.

The Role of Family and Resident Wishes
- The consideration of family and resident wishes would be rated as more important to the decision-making process when physicians felt that they were more aware of these wishes.
- The consideration of family wishes would be rated as more important to the decision-making process when the resident was more cognitively impaired.
- Rating of family satisfaction with the decision would be higher when the consideration of family wishes was considered more important to the medical decision.

The Impact of Short Life Expectancy
- The consideration of prolongation of life would be rated as less important to the decision-making process when life expectancy was less than 3 months.
- In making the decision for a person with a life expectancy of less than 3 months, the physician would consider more passive and fewer active treatments than for those with a longer life expectancy.

Determinants of Physician Satisfaction
- Rating of the physicians' satisfaction would be related to ratings of families' satisfaction as well as to whether the decisions fit what the physicians would wish for themselves, and related to what the physician thought the resident would wish for herself/himself.

RESULTS

Description of the Decision-Making Process

Physicians' familiarity with the resident and family.—For 47% of the participants, the physician on call participated in the decision rather than their personal physician. Physicians lacked familiarity with 70% of the residents' wishes concerning care, felt somewhat familiar with their wishes in 17% of cases, and felt either familiar or very familiar with the residents' wishes in only 13% of the cases. However, physicians felt more knowledgeable about the families' wishes, expressing familiarity (familiar or very familiar) with family wishes in 51% of cases. They claimed to be unfamiliar with the families' wishes in only 19% of the cases.

Sixty-eight percent of the residents had an estimated life expectancy of greater than 3 months, whereas 10% had a life expectancy of less than 3 months. The physicians did not know the life expectancy for 22% of the residents.
Physicians’ Decision Making

Nature of status change event.—The most common incidents during status change events were trouble breathing (29%), aspiration/pneumonia (11%), fracture (11%), and hypotension (10%) (Table 2). Many of the residents experienced multiple incidents during a status change event. The residents averaged 1.5 incidents per person, with 65.2% having 1 incident, 26.1% having 2 incidents, 7.2% having 3 incidents, and 1.4% having 4 incidents. However, multiple incidents could be related. For example, chest pain and trouble breathing could be rated as two separate incidents yet have the same underlying condition. In 63% of the cases, residents had a history of medical problems related to these events.

Perceived severity of status change event.—The physicians estimated that more than half (55%) of the events were acutely life threatening, and 38% were not acutely life threatening; in 7% of the events, physicians were unable to evaluate the degree of threat.

Treatments considered and chosen.—Hospitalization was the most frequently cited treatment considered and chosen (Table 3). It was considered for 76% of the cases and chosen for 39%. Medication was considered for 45% of cases and chosen for 36%. Diagnostic testing, although considered for 33% of the cases, was chosen for only 18%. Comfort care was considered in 28% of the cases but was chosen for only 13% of the cases. Observation was considered for 27% of cases and chosen for 18% of cases. On average, there were 2.7 treatments considered (range 1–7 treatments) and 1.6 treatments chosen (range 0–4 treatments).

Passive treatments were used in 37% of the cases, in which 21 residents (31%) had 1 passive treatment and 4 residents (6%) had 2 passive treatments. In contrast, active treatments were used in 84% of the cases, in which 37 residents (55%) had 1 active treatment, 14 (21%) had 2 active treatments, and 5 (8%) had 3 active treatments. Number of treatments considered and chosen varied significantly with the specific physician involved. (Analysis of variance’s [ANOVA] comparing the different physicians: passive treatment considered, \( p = .01 \); passive treatment chosen, \( p = .03 \); active treatment considered, \( p < .01 \); number of treatments considered, \( p < .01 \); number of treatments chosen, \( p = .03 \); ANOVA for number of active treatments chosen was not statistically significant).

Table 2. Frequency of Incidents During Status Change Events

<table>
<thead>
<tr>
<th>Incident</th>
<th>N (%) Incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trouble breathing</td>
<td>20 (28.6)</td>
</tr>
<tr>
<td>Aspiration/pneumonia</td>
<td>8 (11.4)</td>
</tr>
<tr>
<td>Fracture</td>
<td>8 (11.4)</td>
</tr>
<tr>
<td>Hypotension</td>
<td>7 (10)</td>
</tr>
<tr>
<td>Heart trouble</td>
<td>6 (8.6)</td>
</tr>
<tr>
<td>Chest pain</td>
<td>6 (8.6)</td>
</tr>
<tr>
<td>Infection</td>
<td>4 (5.7)</td>
</tr>
<tr>
<td>Not eating/weight loss</td>
<td>4 (5.7)</td>
</tr>
<tr>
<td>Fall</td>
<td>4 (5.7)</td>
</tr>
<tr>
<td>Fever</td>
<td>4 (5.7)</td>
</tr>
<tr>
<td>Cerebrovascular accident</td>
<td>3 (4.3)</td>
</tr>
<tr>
<td>Trouble swallowing</td>
<td>3 (4.3)</td>
</tr>
<tr>
<td>Lethargy</td>
<td>2 (2.9)</td>
</tr>
<tr>
<td>Unresponsiveness</td>
<td>2 (2.9)</td>
</tr>
<tr>
<td>Continuous vomiting/dehydration</td>
<td>2 (2.9)</td>
</tr>
<tr>
<td>Other*</td>
<td>17 (24.3)</td>
</tr>
</tbody>
</table>

Note: \( N \) [number] = 70 residents; 34.8% of residents experienced more than 1 event.

* Other incidents that occurred in only one resident each were passing out, breast mass carcinoma, severe stomach pain, inability to speak clearly/agitated and confused, leg pain, laceration, diabetes, right thigh swelling, abnormal laboratory result, change in mental health, chest radiograph result, shaking chills, psychological depression, change in consciousness, end stage of Parkinson disease, trouble walking, nausea, fecal impaction, and distress.
Table 3. Treatment Options Considered and Chosen

<table>
<thead>
<tr>
<th>Variable</th>
<th>Treatment Considered</th>
<th>Treatment Chosen</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Hospitalization</td>
<td>51</td>
<td>76.1</td>
</tr>
<tr>
<td>Medication</td>
<td>30</td>
<td>44.8</td>
</tr>
<tr>
<td>Diagnostic tests</td>
<td>22</td>
<td>32.8</td>
</tr>
<tr>
<td>Comfort care</td>
<td>19</td>
<td>28.4</td>
</tr>
<tr>
<td>Observation</td>
<td>18</td>
<td>26.9</td>
</tr>
<tr>
<td>In-house treatment</td>
<td>10</td>
<td>14.9</td>
</tr>
<tr>
<td>Other*</td>
<td>11</td>
<td>16.4</td>
</tr>
<tr>
<td>Radiograph</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Intravenous treatment</td>
<td>11</td>
<td>16.4</td>
</tr>
<tr>
<td>Oxygen</td>
<td>3</td>
<td>4.5</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Surgery</td>
<td>1</td>
<td>1.5</td>
</tr>
<tr>
<td>Amputation</td>
<td>1</td>
<td>1.5</td>
</tr>
</tbody>
</table>

* Other treatments considered once: clysis, intubation, cardio-pulmonary resuscitation/send to emergency room, tube feeding, immobilization, no treatment, wait until the next day, nebulizer treatment, routine care, supportive intervention, emergency room, and psychiatric hospital.

Note: N [number] = 67; three cases were missing data due to unanswered section in questionnaire.

Table 4. Importance of Different Considerations in Making Treatment Decisions

<table>
<thead>
<tr>
<th>Consideration</th>
<th>Importance, Mean Score*</th>
<th>N/A and Not Important at All, N</th>
<th>Somewhat Important, N</th>
<th>Important, N</th>
<th>Very Important, N</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident’s quality of life</td>
<td>3.0</td>
<td>16</td>
<td>3</td>
<td>8</td>
<td>36</td>
<td>63</td>
</tr>
<tr>
<td>Relative effectiveness/futility of treatment options</td>
<td>2.98</td>
<td>12</td>
<td>7</td>
<td>14</td>
<td>30</td>
<td>67</td>
</tr>
<tr>
<td>Family’s wishes</td>
<td>2.95</td>
<td>15</td>
<td>3</td>
<td>15</td>
<td>30</td>
<td>67</td>
</tr>
<tr>
<td>General treatment practice for this condition</td>
<td>2.44</td>
<td>11</td>
<td>25</td>
<td>15</td>
<td>12</td>
<td>68</td>
</tr>
<tr>
<td>Prolongation of resident’s life</td>
<td>2.04</td>
<td>25</td>
<td>15</td>
<td>18</td>
<td>5</td>
<td>68</td>
</tr>
<tr>
<td>Potential liability issues</td>
<td>2.00</td>
<td>24</td>
<td>21</td>
<td>12</td>
<td>6</td>
<td>68</td>
</tr>
<tr>
<td>Resident’s wishes</td>
<td>1.92</td>
<td>40</td>
<td>1</td>
<td>9</td>
<td>13</td>
<td>63</td>
</tr>
<tr>
<td>Cost of alternative treatments</td>
<td>1.7</td>
<td>38</td>
<td>7</td>
<td>17</td>
<td>1</td>
<td>63</td>
</tr>
<tr>
<td>Physician’s preference if he/she were in the resident’s place</td>
<td>1.7</td>
<td>25</td>
<td>2</td>
<td>3</td>
<td>6</td>
<td>36</td>
</tr>
</tbody>
</table>

Note: N [number] = 63; seven cases were missing data due to unanswered section in the questionnaire.

* Considerations were rated on the following scale: 1 = N/A [not applicable] and not important at all; 2 = somewhat important; 3 = important; 4 = very important.

When asked who else was involved in making the medical decision, physicians indicated that family members (son, daughter, wife, niece, nephew, sister, and son-in-law/daughter-in-law) were most frequently involved (42%), followed by nurses (34%), other physicians (9%), social workers (2%), and others, for example, a resident’s friend or rabbi (5%); for 29%, no one else was involved. The values total more than 100% because for some cases, more than one other person was involved (N = 66; four cases were missing data due to an unanswered section on the questionnaire).

Persons involved in making the care decision.—When asked who else was involved in making the medical decision, physicians indicated that family members (son, daughter, wife, niece, nephew, sister, and son-in-law/daughter-in-law) were most frequently involved (42%), followed by nurses (34%), other physicians (9%), social workers (2%), and others, for example, a resident’s friend or rabbi (5%); for 29%, no one else was involved. The values total more than 100% because for some cases, more than one other person was involved (N = 66; four cases were missing data due to an unanswered section on the questionnaire).

Considerations in making treatment decisions.—The most important considerations in making a decision were reported to be the resident’s quality of life, the relative effectiveness of the treatment options, and family wishes (Table 4). Cost of alternate treatments and the resident’s wishes, which were frequently unavailable, were least important. However, the physician reported being at least somewhat familiar with the wishes of only 21 residents. For these, there was a near-significant correlation between familiarity and importance attributed to residents’ wishes (r = .45, p = .05).

There were significant differences across physicians in the ratings of importance of the different considerations. When comparing the ratings of each of the five physicians who had completed at least nine questionnaires and the collective group of the other physician and three nurse practitioners, there were significant differences in ratings at the .01 level for six considerations: potential liability issues, general treatment practice for this condition, cost of alternate treatments, resident’s quality of life, family’s wishes, and prolongation of resident’s life.

Evaluation of the decisions.—The physicians evaluated their feelings about the decision as very positive for 18% of the residents, positive for 45%, comfortable for 27%, and indifferent for 3%. Ratings were somewhat negative and very negative for 2% and 5%, respectively. For the negatively rated decisions, physicians would have wanted less treatment (three decisions) or more treatment (one decision). When asked to evaluate their perceptions of the family caregiver’s feelings about the decision, the physicians assessed it as very positive in 15% of the events, positive in 32%, comfortable in 19%, and somewhat negative in 3%. They could not evaluate the family’s feelings in 31% of the events (N = 68; two cases were missing data due to an unanswered section on the questionnaire).

In evaluating the medical impact of the treatment, physicians expected two-thirds (66%) of the residents who were alive to improve (relative to their condition immediately after the event), expected treatment to limit deterioration for 9%, and expected treatment would not make a difference for 14%. The physicians were unsure about the impact of treatment for the other residents (11%) (N = 68; 14 cases were missing data due to an unanswered section on the questionnaire).

When trying to evaluate the patient’s perspective, the physicians were asked, “If the patient could tell you, what do you think he/she would want as his/her treatment?” For over half of the residents (63%), the physicians thought that the resident would have chosen the same action as was
Relationship Between Process and Outcome Variables

We evaluated the following hypotheses.

The role of family’s and resident’s wishes

- The importance of the consideration of family wishes was significantly related to physicians’ familiarity with those wishes ($r = .37, p < .01$). In contrast, the relationship between the importance of residents’ wishes and the knowledge of those wishes was not significant ($p = .06$), when including all residents in the correlation. As mentioned above, if only residents for whom the physician was at least somewhat familiar with their wishes are included, there is a positive correlation between familiarity with residents’ wishes and the importance ascribed to those wishes.

- The consideration of family wishes was rated as more important to the decision-making process when the resident was more cognitively impaired ($r = .35, p < .01$).

- Rating of family satisfaction with the decision was higher when consideration of family wishes was considered more important to the medical decision ($r = .45, p < .01$).

The impact of short life expectancy

- The consideration of prolongation of life was rated as less important to the decision-making process when life expectancy was less than 3 months ($t_{15} = 3.0, p < .01$).

- In making the decision for a person with a life expectancy of less than 3 months, the physicians did consider and choose more passive treatments ($t_{52} = 3.3$, and $t_{52} = 3.0$ respectively, $p < .01$ for both); however, they also considered more active treatments ($t_{52} = 2.7, p < .01$). There was no significant relationship with the number of active treatments chosen.

Determinants of physician satisfaction

- Rating of the physicians’ satisfaction was related to ratings of families’ satisfaction ($r = .43, p < .01$). Physicians’ satisfaction with the decision was higher when the decision was the same as what they would have wanted for themselves than when it was different ($t_{50} = 2.5, p < .05$). The physician’s satisfaction was not related to whether the decision fit what the physician thought the resident would want for himself/herself ($n = 50, p = .07$). However, for most of those residents, the physician was speculating on the wishes of residents whose wishes they were not familiar with.

Discussion

The medical decision process at the time of a status change event is complex, involving many types of events, multiple symptoms, and a degree of uncertainty about etiology. Many different treatments are considered, and the decision generally involves either an active route, such as hospitalization, or a passive one, such as comfort care.

In rating the importance of considerations for making the decision, physicians rated quality of life as the highest, and clearly higher than prolongation of life. Families’ wishes were also rated as important, whereas residents’ wishes were given lower importance, probably because they were most often not available. For the three considerations that tended to be rated as highest (i.e., quality of life, effectiveness of treatment options, and family’s wishes), these considerations tended to be rated as either very important or not important rather than given intermediary ratings. In contrast, less important considerations received low ratings more often. Nevertheless, all considerations received ratings of “very important” for at least some of the residents. These findings show that considerations related to multiple factors (Figure 2) were viewed as important, including personal, medical, and autonomy factors, without any single factor dominating the physicians’ considerations.

Considerations were related to a resident’s status and to the physician–resident relationship. When relatively imminent death was anticipated, prolongation of life was rated as less important. Similarly, residents’ cognitive impairment resulted in higher importance attributed to relatives’ wishes. Physicians’ level of familiarity with wishes also was associated with the importance attributed to those wishes.

We found significant differences among individual physicians in the ratings of the factors that impact their decisions and in the number of treatments considered and chosen, highlighting the importance of individual physician style of practice and of reporting this practice. This finding is consistent with the study of Eisemann and colleagues (3) of vignette-based decision-making for incompetent elderly persons by physicians of three European countries. They found significant differences among the countries in treatment decisions and in the level of importance ascribed to considerations, such as patient’s or family’s wishes, in making a decision. Similarly, Kellogg and Ramos (4) found that Do Not Resuscitate decisions were more likely to be made by specific physician and social worker teams than by others.

The physicians were satisfied with the decision-making process in the vast majority of the events and thought that the family members and the nursing staff were pleased with it. Physicians expressed satisfaction with the decision even when they would have opted for a different treatment for themselves. However, they tended to feel even more satisfied when the decision matched their preferences for treatment for themselves had they been in the resident’s
condition. Their perceptions of the concordance between the hypothesized resident’s preferences and the treatment provided were not significantly related to their own satisfaction with the decision. Conversely, there were a few cases in which they were displeased with the decision when the decision was different from how they would have wanted to be treated. Perceived family satisfaction was related to the importance of family wishes in making the decision.

Future research needs to examine several issues concerning the considerations, including:

- What is the meaning of “cost” as a consideration? Whose cost is it, given that most hospitalizations are paid for by Medicare, and most other treatments are included in the family’s regular payment to the nursing home?
- What is the relative impact of the physician versus that of the patient or the situation in determining the importance of a consideration?
- Do considerations mediate between the situational factors (resident condition, i.e., nature of status change event, family wishes, etc.) and the decisions, or do they merely reflect the situational factors? That is, is there a difference between decisions made directly in response to the situational factors and decisions made taking into account the considerations (e.g., importance of family wishes or prolongation of life) related to each situation?
- What is the relative’s perspective on this process and how does it compare to the physician’s perception?

This study demonstrates how the decision-making process can be investigated and what may be some of the trends in this process, thus paving the way to these future studies.

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Address correspondence to Jiska Cohen-Mansfield, PhD, ABPP, Director, Research Institute on Aging, Hebrew Home of Greater Washington, 6121 Montrose Rd. Rockville, MD 20852. E-mail: cohen-mansfield@hebrew-home.org

REFERENCES


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Appendix 1

Medical Decision-Making During a Status Change Event Questionnaire
(©Jiska Cohen-Mansfield)

[Note to users: When printing questionnaire, provide additional lines for space to elaborate after each question.]

| Background |
|-----------------|-----------------|-----------------|-----------------|
| **Physician name:** | Dr. A | Dr. B | Dr. C | Dr. D | Dr. E | Dr. F |
| NP A | NP B | NP C |
| **Physician’s Characteristics** | Gender: Male | Female |
| **Years of experience in geriatrics:** | | |
| **Years at this nursing home:** | | |
| **Research Assistant name:** | | |
| **Resident name:** | | | **ID#:** | |
| **Unit:** | | | **Date:** | |

1. Is this your resident?
   Yes  No

2. If yes, then how long have you been treating the resident?

Please rate how familiar you are with each of the following items.

3. How familiar are you with the family’s wishes concerning the resident’s care?
   Not familiar  Somewhat familiar  Familiar  Very familiar

4. How familiar are you with this resident’s wishes concerning care?
   Not familiar  Somewhat familiar  Familiar  Very familiar
Nature and severity of status change event

5. What occurred in the recent event?
   Infection  CVA  Aspiration/pneumonia  Trouble swallowing  Fracture
   Trouble breathing  Not eating/weight loss  Passed out  Chest pain  Other (specify in 5a)

5a. ________________________________

6. Before the acute event, would you have estimated the resident’s life expectancy to be less than 3 months?
   Yes  No  Don’t Know

7. Is/Was the change acutely life-threatening? **note: this question was deleted from the questionnaire pertaining to residents who died by the time of the interview
   Yes  No  Don’t Know

8. Does the resident have a history of medical problems related to this event/change?
   Yes  No  Don’t Know

Decision-making process

9. What options did you consider for treating this situation?
   Medication  Comfort Care  Rehabilitation  Observation  Diagnostic tests  Hospitalization  Surgery  IV  Amputation  Dialysis  Blood transfusion
   Radiation  Other (specify in 9a.)

9a. ________________________________

10. What options did you choose for treating this situation?
    Medication  Comfort care  Rehabilitation  Observation  Diagnostic tests  Hospitalization  Surgery  IV  Amputation  Dialysis  Blood transfusion
    Radiation  Other (specify in 10a.)

10a. ________________________________

11. Who else was involved in making the care decision regarding this resident?
   Nurse  11a. specify who__________________________
   Social worker  11b. specify who__________________________
   Other physician  11c. specify who__________________________
   Family member  11d. specify who__________________________
   Other  11e. specify who__________________________
   No one

Considerations in making treatment decisions

12. Why did you choose the above treatments?
    Please rate how important the following considerations were in your treatment decisions, using the following scale.

    Relative effectiveness/futility of treatment options
    Not important at all  Somewhat important  Important  Very important

    Potential liability issues
    Not important at all  Somewhat important  Important  Very important

    General treatment practice for this condition
    Not important at all  Somewhat important  Important  Very important

    Cost of alternative treatments
    Not important at all  Somewhat important  Important  Very important

    Resident’s quality of life
    Not important at all  Somewhat important  Important  Very important

    Family’s wishes
    Not important at all  Somewhat important  Important  Very important

    Resident’s wishes
    Not important at all  Somewhat important  Important  Very important

    Prolongation of resident’s life
    Not important at all  Somewhat important  Important  Very important

    Resident’s advance directive **note: this question was added to the questionnaire late, and thus is not addressed in this paper
    Not important at all  Somewhat important  Important  Very important

    Your own preference if you were in the resident’s place
    Not important at all  Somewhat important  Important  Very important

    Other (specify in 12a.)
    Not important at all  Somewhat important  Important  Very important

12a. ________________________________
Evaluation of the decision

13. What is the likelihood that this treatment will improve the patient’s condition as compared to the patient’s condition immediately after the status change event?
   Likely to improve  Likely to limit deterioration  Unsure  Not likely to make any difference
   Other (specify in 13a.)

13a. __________________________

**note: for the questionnaire pertaining to residents who died, the previous question was changed to:**

13. Was the patient’s death caused by the:
   Status change event  Treatment  Both  Neither  Chronic illness  Lack of treatment  Don’t know

14. How does the family feel about the decision?
   Very positive  Positive  Comfortable  Indifferent  Somewhat negative  Very negative  Don’t know

15. How do you feel about the decision?
   Very positive  Positive  Comfortable  Indifferent  Somewhat negative  Very negative  Don’t know

16. If the patient could tell you, what do you think he/she would want as his/her treatment?
   __________________________
   (This was coded as: less treatment, same, more treatment, other treatment)

17. If you were this patient (in his/her condition and age), what treatment option would you most want attempted?
   __________________________
   (This was coded as: less treatment, same, more treatment, other treatment)

18. Additional comments  __________________________

Note: CVA = cerebrovascular accident; IV = intravenous.